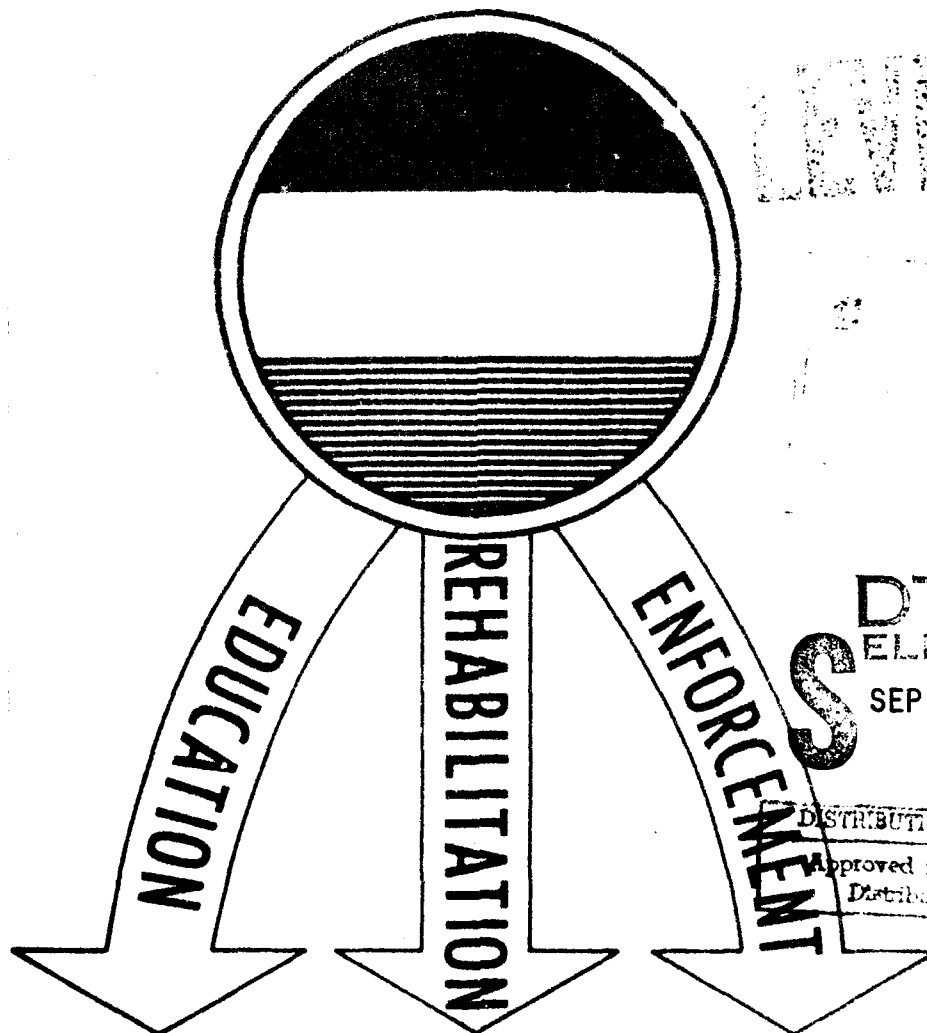


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UNITED STATES CONTINENTAL ARMY COMMAND

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**DRUG ABUSE & ALCOHOLISM
CONTROL PROGRAM**

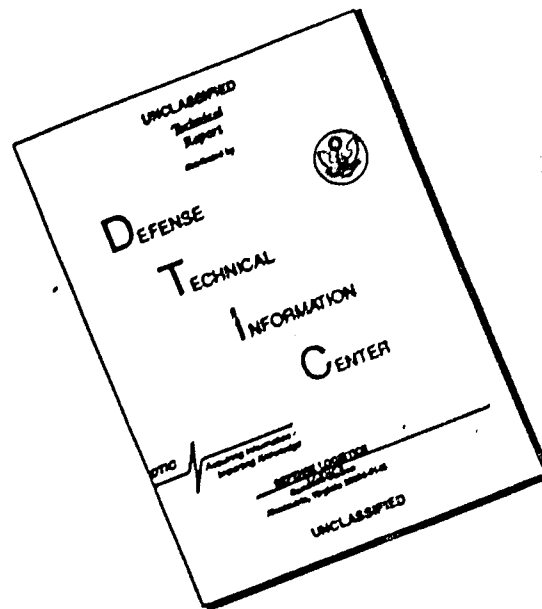
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DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES CONTINENTAL ARMY COMMAND
FORT MONROE, VIRGINIA 23361

ATDCG

24 September 1971

SUBJECT: Drug Abuse and Alcoholism

SEE DISTRIBUTION

1. Drug abuse problems within the Army have recently been identified as increasing rapidly in magnitude and complexity. Parallel experience in the civil sector is extensive among late adolescents and young adults. Our young soldiers are drawn from a society where participation in contemporary social patterns often includes experimentation with a variety of potentially dangerous drug chemicals. The recent expansion of this serious problem within the Army demands concerted command participation and support in immediate, strong, and continuing efforts to reduce improper use of drugs by military personnel. Although a dichotomy between alcoholism and drug abuse is recognized, the medical and psychological similarities dictate a unified approach in planning and implementation of efforts to curb misuse of these substances within the Army.

2. The Commanding General has directed a triaxial program of education, rehabilitation, and law enforcement to counter drug and alcohol abuse problems within CONARC, as outlined in the accompanying program.

3. Central to success of this program is provision of credible troop information and conduct of intensified education programs emphasizing the physiological and psychological dangers and the moral and legal implications of both alcoholism and drug abuse. Full details of the Army's exemption and rehabilitation programs will receive the widest dissemination to assist the potential volunteer in seeking help. Concurrently, positive steps will be taken to identify alcohol and drug abusers at the earliest possible moment and insure that competent medical attention is available and accessible. The recent DOD drug use testing program in Southeast Asia has helped identify returnees who require continued medical supervision. A complete program of follow-up rehabilitative services is necessary for these personnel.

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4. "Operation Awareness" conducted at Fort Bragg highlighted the importance of the Army's cooperative efforts with local civilian law enforcement agencies in the battle against drug abuse. The major gain of such programs is the inroad they provide to finding the source of distribution of dangerous drugs -- our primary requirement for law enforcement. Another factor of significant impact to our law enforcement efforts is strict implementation of current Department of the Army policies on disciplinary and administrative actions against drug abusers who cannot be rehabilitated.

5. A vigorous and sustained effort will be made at all levels of command on the voluntary rehabilitation of those personnel intemperate in the use of alcohol. As with the drug abusers, administrative action will be expedited against those who cannot be rehabilitated. This is particularly applicable with those who hold positions of leadership or of responsibility in dealing with people.

6. Some would have us accept the Army's drug abuse problem as solely inherited from our society. This is a misplaced conception. We must not eschew our responsibility to society during this time of moral crisis. We in the Army have fortunately recognized our drug and alcohol abuse problems. It is now time for an all-out attack against both.

1 Incl
CONARC Drug Abuse
and Alcoholism
Control Program


JOHN J. TOLSON
Lieutenant General, USA
Deputy Commanding General

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HEADQUARTERS
UNITED STATES CONTINENTAL ARMY COMMAND
DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

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HEADQUARTERS
UNITED STATES CONTINENTAL ARMY COMMAND
DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

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CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

SECTION I - Background

A. The initial formalized and standardized Army-wide effort aimed at reducing drug abuse commenced with the publication of AR 600-32 which became effective 1 Dec 1970.

B. The President of the United States added further impetus to the Army's effort when he directed that the critical national problem of drug abuse be given urgent and immediate attention.

C. On 17 June 1971, the Secretary of Defense directed the Secretary of the Army, as a matter of urgent priority, to develop and implement a counter offensive plan designed to meet the problem of drug abuse among Army personnel. Accordingly, the Chief of Staff of the Army has directed that this program be assigned the highest priority.

D. Department of the Army issued preliminary planning guidance and a phased planning schedule as follows:

1. Commence urine testing for opiates in VN on 19 June 1971.
2. Commence urine testing for amphetamines, barbiturates, methadone, and opiates for selected personnel within CONUS by 1 August 1971.
3. Submit lessons learned from drug abuse prevention efforts on quarterly basis. First report due 15 October 1971.
4. Select and train personnel for the establishment of Drug Education Specialist Program by 15 October 1971.
5. Participate in world-wide spot check and treatment by 1 November 1971.

E. Further DA guidance required major subordinate commands to develop "Halfway House" facilities and to support drug abuse programs with available resources until DA obtains additional funds and trains and allocates additional personnel.

SECTION II - Purpose

The purpose of this program is to provide guidance and direction for the conduct of a comprehensive Drug Abuse and Alcoholism Control Program at all levels within CONARC.

SECTION III - Objective

To prevent and control drug abuse and alcoholism within CONARC through education and training, identification and rehabilitation, and law enforcement.

SECTION IV - Applicability

The provisions of this program are applicable to all Army military personnel, dependents, and Department of the Army civilian employees within CONARC as indicated. Provisions of AR 600-32 and CON Suppl 600-32 in conflict with this directive are superseded pending their revision.

SECTION V - Glossary of Terms

For explanation of pertinent terms to be used by subordinate commands see Annex A.

SECTION VI - Policy

The HQ CONARC policy is to:

1. Recognize that drug and alcohol abuse is a problem within CONARC which demands positive command interest and support.
2. Accept that the similarities of drug and alcohol abuse dictate a unified approach in planning and implementation of effort.
3. Encourage Army personnel to submit themselves voluntarily for treatment and rehabilitation without prejudice.
4. Restore and rehabilitate those personnel who evidence a desire and willingness to undergo such programs.
5. Insure that administrative and disciplinary actions taken in instances of drug abuse and alcoholism are based on the individual circumstances of each case.
6. Provide treatment and rehabilitation services to other members of the Army community within CONARC.

SECTION VII - Implementation

A. GENERAL. The CONARC Drug Abuse and Alcoholism Control Program encompasses three functional areas:

1. Education and training designed to inform all personnel within the Army community of the physiological, psychological, and moral implications of drug and alcohol abuse.
2. Identification and rehabilitation designed to treat and restore the drug and alcohol abuser.
3. Law enforcement directed primarily to suppress the illegal source, particularly with respect to drugs.

B. RESPONSIBILITIES.

1. Major CONARC subordinate commands:

a. Develop and implement a Drug Abuse and Alcoholism Control Program consistent with the command's mission and sensitivity and in accordance with this document. Submit 5 copies to this headquarters, ATTN: DCSPER-DAACD.

b. Accomplish tasks per Annex B.

c. Conduct periodic survey of resource requirements and advise this headquarters of short-fall.

d. Submit reports in accordance with Annex C.

e. USAJFKCENMA: Conduct drug and alcohol abuse surveys as required utilizing the 13th PSYOP Bn, 2d PSYOP Group.

2. HQ CONARC:

a. Alcohol and Drug Dependency Intervention Council (ADDIC) see Appendix 2, Annex A.

(1) Advise the Commanding General on matters of policy and programs of prevention and rehabilitation.

(2) Conduct periodic review and recommend changes to CONARC's Drug Abuse and Alcoholism Control Program.

b. DEPUTY CHIEF OF STAFF FOR PERSONNEL:

(1) Establish a Drug Abuse and Alcoholism Control Division (DAACD) to:

(a) Serve as program coordinator for the CONARC Drug Abuse and Alcoholism Prevention Control Program.

(b) Serve as Executive Secretary of the CONARC Alcohol and Drug Dependency Intervention Council (ADDIC).

(2) Coordinate all personnel actions and provide, as appropriate, personnel required to support this program.

c. DEPUTY CHIEF OF STAFF FOR INDIVIDUAL TRAINING: Establish and coordinate policies and procedures for individual training related to drug abuse and alcoholism.

d. DEPUTY CHIEF OF STAFF FOR MILITARY OPERATIONS AND RESERVE FORCES: Establish and coordinate policies and procedures for unit training related to drug abuse and alcoholism.

e. DEPUTY CHIEF OF STAFF FOR LOGISTICS: Establish and coordinate policies and procedures concerning logistic matters involved in the planning and implementation of this program.

f. DEPUTY CHIEF OF STAFF FOR FORCE DEVELOPMENT: Determine and provide initial and ongoing manpower space requirements necessary for implementation and support of this program.

g. DEPUTY CHIEF OF STAFF COMPTROLLER: Determine and provide initial and ongoing funding necessary for implementation and support of this program.

h. DEPUTY CHIEF OF STAFF FOR INTELLIGENCE: Coordinate policies and procedures pertaining to security and intelligence matters related to drug abuse and alcoholism.

i. SURGEON: Establish and coordinate CONARC policies and procedures pertaining to the medical aspects of this program.

j. CHAPLAIN: Establish and coordinate chaplain participation in this program.

k. STAFF JUDGE ADVOCATE: Provide assistance/advice on legal matters, as required.

1. INSPECTOR GENERAL:

(1) Determine compliance by commanders with the CONARC Drug Abuse and Alcoholism Control Program.

(2) Receive, investigate and report on allegations, complaints and grievances concerning all aspects of this program.

m. PROVOST MARSHAL:

(1) Establish and coordinate policies and procedures regarding the suppression of illegal drugs.

(2) Cooperate and coordinate with federal, state and local law enforcement agencies concerning alcohol and drug abuse.

n. INFORMATION OFFICER:

(1) Implement and coordinate command and public information programs.

(2) Provide guidelines on community relations, as appropriate.

C. CONDUCT OF THE PROGRAM.

1. Education and Training (Annex C)
2. Rehabilitation (Annex D)
3. Law Enforcement (Annex E)
4. Resource Requirements (Annex F)
5. Information Program (Annex G)
6. Reports (Annex H)

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ANNEX A (Glossary of Terms) to CONARC DRUG ABUSE AND ALCOHOLISM
CONTROL PROGRAM

1. PURPOSE. To explain pertinent terms used in CONARC Drug Abuse and Alcoholism Control Program.

2. EXPLANATION.

a. Abuser: One who has illegally, wrongfully or improperly used alcohol, controlled substances, or other intoxicants, or who has illegally or wrongfully possessed, sold, transferred, delivered or manufactured the same.

b. Alcohol Abuser: An alcoholic or problem drinker.

c. Alcoholic: An individual whose alcohol consumption pattern is clinically determined to be within the definition of alcoholism.

d. Alcoholism: Chronic disease, or disorder of behavior characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with social drinking customs of the community, and which interferes with the drinker's health, interpersonal relations, or economic functioning.

e. Alcohol and Drug Dependency Intervention Council (ADDIC):
See Appendix 2, this annex.

f. Amphetamines: Class of strong central nerve system stimulants; examples are benzedrine, dexedrine, and methedrine.

g. Army Community: Army community includes:

(1) Members of the regular Army, including those awaiting separation after expiration of their terms of enlistment; volunteers from the time of their muster of acceptance into the Army; inductees from the time of their actual induction into the Army; and those other persons lawfully called or ordered into, or to duty in, or for training in the Army from the dates when they are required by the terms of the call or order to obey it.

(2) Cadets at the US Military Academy.

(3) Members of the Army Reserve while they are on active duty for training authorized by written orders which are voluntarily accepted by them and which specify that they are subject to the UCMJ.

(4) Retired members of the Army who are entitled to retired pay.

(5) Persons serving with or accompanying the Army, such as civilians working for the Army in RVN.

(6) Dependents of military personnel.

h. Barbiturates: Class of central nervous system depressants; examples are seconal, nembutal and tuinal.

i. Caretaker: A person in a rehabilitative facility charged with non-therapeutic duties to provide supervision and administrative support to the overall therapeutic program within the halfway house and "RAP" center programs.

j. Casual Supplier: One who furnishes illegally, wrongfully or improperly to another person a small amount of the drugs defined herein for the convenience of the user, rather than for gain.

k. Controlled Substances: Those substances prescribed for general use by 21 USC 812 and the regulations in implementation thereof promulgated by the Attorney General.

l. Counselor/Caretaker: An interested, highly motivated person with specialized background, but lacking any specialized training or education, who, through on the job training, is competent to work in a therapeutic role with patients in the rehabilitation program, under the supervision of a trained counselor.

m. Drug Abuse: The illegal, wrongful or improper use of any controlled substance or intoxicants other than alcohol or the illegal or wrongful possession, sale, transfer or manufacture of the same. When such drugs have been purchased for their intended use or prescribed by competent medical personnel for medical purposes, their proper use by the patient prescribed for is not drug abuse.

n. Drug Abuser: One who has illegally, wrongfully, or improperly used any controlled substance or intoxicant other than alcohol or who has illegally, wrongfully or improperly possessed, sold, transferred, delivered or manufactured the same.

(1) Drug Experimenter: One who has illegally, wrongfully, or improperly used any controlled substance or intoxicants other than alcohol, as defined herein not more than a few times for reasons of curiosity, peer pressure, or other similar reasons. The exact number of usages is not necessarily as important in determining the category of user as is the intent of the user, the circumstances of use, and the psychological makeup of the user.

(2) Drug User: One who has illegally, wrongfully, or improperly used any controlled substance or intoxicants other than alcohol, as defined herein several times for reasons of a deeper and more continuing nature than those which motivate the drug experimenter.

(3) Drug Dependent Individual: One who exhibits a behavioral pattern of compulsive drug use, characterized by overwhelming involvement with the use of a drug, and the securing of its supply. As the term "drug dependent individual" is used herein, one may or may not be physically dependent on the drug. Rather, the term refers in a quantitative sense to the degree to which drug use pervades the total life activity of the user.

o. Drug Counselor: Individual who has specialized training or education to provide counseling services; e.g., chaplain, social worker, rehabilitation worker, psychiatrist, psychologist, or enlisted specialist.

p. Drug Education Specialist: See Appendix 1, Annex C.

q. Exemption: See Appendix 1, Annex A.

r. Exemption Representative: An individual designated by the commander to assist individuals seeking exemption. This individual should possess qualities essential to successful administration of the program, i.e., maturity, responsibility and verbal skills.

s. Halfway House: See TAB A, Appendix 3, Annex D.

t. Marijuana: Intoxicating products of the Indian hemp plant, *cannabis sativa*, or any synthesis thereof, including hashish. Tetrahydrocannabinol (THC), the active ingredient of marijuana, is a strong hallucinogen with sedative properties.

u. Medical Department Activity (MEDDAC): An organizational structure established at an installation having a US Army hospital located thereon. Its organizational structure may include various fixed medical service activities on the installation and/or off-post.

v. Mobile Education Teams (METS): Special multidisciplinary teams who travel to selected installations in their respective geographical areas to conduct workshops to train personnel in: The identification of problem drinkers and drug users; the recognition of personal difficulties and problem areas; programing for alcohol and drug abuse education leadership. Mobile education teams may include such persons as behavioral science specialists, medical personnel, chaplains, educational specialists for program guidance, discussion group leader trainers, military policemen, ex-alcohol and drug dependent personnel as appropriate.

w. Narcotics: Opium and pain-killing drugs made from opium, such as, heroin, morphine, paregoric, and codeine. These drugs depress the central nervous system. Also included under federal law as narcotics are cocaine and specially defined synthetic drugs, called opiates.

x. Other Intoxicants: That class of legally available substances which, when inhaled, ingested or injected improperly create an intoxicating effect on the user. Examples are: Airplane glue, massive doses of certain over the counter cough medicines, drugs concocted from over the counter medicines for the purpose of injection or injection.

y. Paraphernalia: Those articles, in such combination, that are reasonable to assume are collected, possessed or sold for the express intent of aiding in the consumption of illegal drugs. Such articles may include combinations such as spoon, cotton and hypodermic needle, but not spoon and cotton alone. Those items usually associated with the consumption of drugs, such as, waterpipes, hashish pipes, etc., which may be used in a decorative manner are permissible only when rendered inoperable as drug consuming appliances.

z. Problem Drinker: An individual whose pattern of alcohol consumption is disruptive to his life, but not of such severity to be classified as an alcoholic.

aa. "RAP" Sessions: Peer group discussions in which participants are encouraged to freely express their ideas or feelings about societal concerns, living circumstances or a particular life situation.

ab. Rehabilitation: The process of restoring a service member to full military duty. It involves the alcohol or drug dependent person changing his life pattern and adjusting to a style of life which does not include alcohol or drug abuse.

ac. Rehabilitation Program: A program of alcohol and drug abuse education, vocational training, outpatient treatment, hospitalization as required, professional counseling, community support, command support and supervision and such other means to rehabilitate alcohol and drug abusers.

ad. Screening: Method by which the Army identifies alcohol and drug abusers to include urine testing, clinical observations and others as appropriate.

ae. Supplier: One who furnishes illegally, wrongfully, or improperly any of the prescribed drugs defined herein to another person.

APPENDICES:

1-Exemption Program

2-Alcohol and Drug Dependency Intervention Council

APPENDIX 1 (Exemption Program) to ANNEX A (Explanation of Terms) to
CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. REFERENCES.

a. AR 600-32, Drug Abuse Prevention and Control, 1 Dec 70, Paragraph 2-5.

b. CON Suppl 1 to AR 600-32, Para 2-5e, dated 4 Jun 71.

2. PURPOSE. To prescribe policy for Army personnel who consider that they have a drug problem and voluntarily submit themselves to appropriate authorities for treatment and rehabilitation.

3. GENERAL. The term "amnesty" is replaced by the term "exemption" to preclude misunderstanding regarding the scope and limitations of the former. The following provisions apply:

a. The objective of the exemption program is to encourage disclosures of drug use and possession incident thereto for the purpose of treating and rehabilitating the user.

b. Exemption means protection from punitive action under the UCMJ or from administrative action leading to a discharge under other than honorable conditions for drug use solely because of volunteering for treatment under the DOD Drug Identification and Treatment Program. This policy does not exempt soldiers from disciplinary or other legal consequences resulting from violations of other applicable laws and regulations, including those laws and regulations relating to the sale of drugs or the possession of significant quantities of drugs for sale to others, if the disciplinary action is supported by evidence not attributable solely to the individual volunteering for treatment under the DOD Drug Identification and Treatment Program. Commanders are required to grant exemption in accordance with this appendix.

c. Exemption does not preclude commanders from taking the following administrative actions:

(1) Suspension of access to classified information or the denial or revocation of security clearances.

(2) Reclassification or withdrawal of Military Occupational Specialities (MOS).

(3) Suspension or revocation of hazardous duty orders.

(4) Administrative discharge from the Army under honorable conditions when the degree or type of drug involvement precludes rehabilitation and return to full duty and the overall character of service, aside from drug abuse, warrants it.

(5) Adverse line of duty determinations until and if relief is obtained from existing Federal statutes.

(6) Other administrative actions, including investigation of criminal activity not directly related to drug use or possession incident to a member's voluntary disclosures.

d. Exemption will be granted only for the illegal use and possession incident to such use of marijuana, narcotics, inhaled substances, or other controlled substances occurring prior to the grant of exemption and revealed through a member's voluntary disclosures at the time of his request for exemption. An individual will usually be granted exemption only once; however, further exemption may be granted in exceptional circumstances as determined by the commander. In any event, the member will be afforded all appropriate rehabilitative measures in accordance with applicable annexes to this plan.

e. Exemption applies only to disclosures which are voluntary and which are made prior to the time a member is apprehended for the drug offense in question or is officially warned by military or civilian authorities that he is suspected of that offense.

f. Identification by urinalysis screening is not a part of this program; however, evidence developed by, or as a direct or indirect result of urinalysis administered for the purpose of identifying drug users may not be used in any disciplinary action under the UCMJ or as a basis for supporting, in whole or part, an administrative discharge under other than honorable conditions.

4. IMPLEMENTATION.

a. Commanders will designate one or more exemption representatives for their commands. When designating representatives, consideration will be given to qualities essential for successful administration of the program, i.e., maturity, responsibility, and verbal skills.

b. Soldiers seeking exemption will be informed that to qualify for exemption they must disclose to the exemption representative their prior drug usage or possession for which they desire exemption. They will also be informed that disclosures to others will not qualify the soldier for exemption. Such disclosures must be made to the exemption representative or the commander concerned.

c. Prior to any disclosure, the exemption representative will fully advise a soldier seeking exemption of the scope and limitations of the exemption program. It must be explained to the exemption applicant that he is not required to identify other drug abusers as a condition precedent to his obtaining exemption.

d. A grant of exemption does not protect the Army member from prosecution in other jurisdictions. Therefore, information obtained incident to a grant of exemption shall not be disclosed outside the military jurisdiction without prior approval of HQ DA, or the designated commanding officer in accordance with AR 27-50, in foreign areas under a Status of Forces Agreement.

e. In the event of resultant administrative processing for separation, evidence of the member's grant of exemption, including the disclosures preceding the grant, may be considered only for the purpose of deciding whether the member shall be retained or separated and not as a basis for characterizing the type of discharge. This rule will apply to boards of officers as well as discharge authorities.

f. The scope and limitations of the Exemption Program will be given extensive publicity. Commanders will ensure that all their personnel are thoroughly familiar with the foregoing provisions.

APPENDIX 2 (Alcohol and Drug Dependency Intervention Council) to ANNEX A
(Glossary of Terms) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. REFERENCES.

a. Letter, AGDS(M) MEDPS-CN, dated 7 December 1970, subject: Alcohol and Drug Dependency Intervention Councils (ADDIC).

b. CONARC message 161825Z Aug 71, subject: Race Relations and Drug Abuse Suppression Councils.

2. PURPOSE. To prescribe policy and procedures for the operation of the command Alcohol and Drug Dependency Intervention Councils (ADDIC).

3. OBJECTIVE. The primary objective of the ADDIC is to advise and assist the commander on matters of alcohol and drug abuse prevention and control.

4. SPECIFIC FUNCTIONS.

a. To serve as a consultative and advisory board to the commander on all aspects of alcohol and drug abuse prevention and control.

b. To develop policies and programs that will contribute to the prevention and control of alcohol and drug abuse with regard to increasing resistance of the individual and the community to alcohol and drug abuse.

c. To periodically assess the alcohol abuse and drug situation in the community and take corrective action, as appropriate.

d. To coordinate programs of alcohol and drug abuse prevention and rehabilitation internally and externally, as appropriate.

e. To provide operational supervision of Halfway House - "RAP" Center.

f. To meet as often as required, but once a month as a minimum.

5. ORGANIZATION.

a. The ADDIC should be chaired by a senior combat arms officer, and should, as a minimum, have representatives from disciplines of preventive medicine, psychiatry, law, social work or psychology, law enforcement, chaplaincy, and the officer-in-charge of the Halfway House - "RAP" Center. Representatives from military and civilian communities, to include dependent schools, dependents, junior officers and enlisted men, may attend and participate at meetings. The requirement for the chairman to be a senior combat arms officer is waived for

combat support and combat service support units. Establishment or participation in joint councils is encouraged.

b. In addition to the command/installation ADDIC, in those areas where multiple installations of one or more services are located (e.g., HQ ARADCOM), Fort Carson, Ent Air Force Base and US Air Force Academy, Colorado Springs, Colorado) a composite service/installation ADDIC should be established to provide a single council.

6. TRAINING. It is desirable that members of the council have experience or specialized training in the technical aspects of drug abuse prevention and control.

ANNEX B (Planning Tasks) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

Task	Action/Monitor	Milestones	Implementation Date
1. Identification, Detoxification/Treatment and Rehabilitation	A- Major Commands M- Surgeon M- DCSPER	Rehabilitation in CONARC (on austere basis)	1 Nov 1971
2. Obtain Lessons Learned from Major Commands	A- Major Commands A- DCSPER	1. Task major commands and Service Schools to submit Lessons Learned from drug abuse prevention efforts. as Lessons Learned 1st report due. 2. Analyze and synthesize Lessons Learned. 3. Disseminate Lessons Learned (Project Assist)	15 Oct 1971 and continuous submission occur
3. Conduct Preventive Drug Abuse Education and Training.			
a. Training per AR 600-32	A- Major Commands & Service Sch M- DCSOPS M- DCSIT	Develop Training and conduct Training Evaluation	Periodically
b. Establishment of Drug Education Specialist Program	A- Major Commands M- DCSPER	Select and Train personnel	15 Nov 1971

ANNEX B (Planning Tasks) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

Task	Action/Monitor	Milestones	Implementation Date
c. Drug Abuse Education Workshops for Officers and NOOs	A- Major Commands M- DCSPER	Select and Train Mobile Education Teams.	30 Nov 1971
4. Evaluate Treatment/Rehabilitation Facilities	A- Major Commands A- DCSPER A- SURGEON	1. Develop and Evaluate Scheme 2. Implement Scheme	Periodically
5. Conduct Alcohol and Drug Abuse Prevention Staff Visits	A- Major Commands A- DCSPER A- SURGEON	Staff visits to installations/activities to evaluate implementation of CONARC Drug Abuse and Alcoholism Control Program	Periodically
6. Conduct Drug and Alcohol Abuse Surveys	A- Major Commands A- 2d PSYOP Group	As Required by Commanders	Periodically
7. Reports	See ANNEX H		As Required

ANNEX C (Education and Training) to CONARC DRUG ABUSE AND ALCOHOLISM
CONTROL PROGRAM

1. PURPOSE. To prescribe policy and provide guidance for the establishment and conduct of drug and alcohol abuse training and education programs. Additionally, this annex will delineate responsibility and proponentcy for the formulation of specific education and training curriculum and provide guidance for the follow-up and evaluation of these programs.

2. OBJECTIVES. Through emphasis of the physiological and psychological dangers as well as moral implications inherent in the use of drugs and alcohol:

a. Insure that the senior personnel of the Army are knowledgeable of all aspects of the drug and alcohol abuse program and are aware of their role in the Drug and Alcohol Abuse Education and Training Program.

b. Convince the nonuser not to experiment and to assist in the endeavor to have drug and alcohol dependent individuals seek help.

c. Convince the experimenter/casual user not to continue his abuse.

d. Inform the drug user/dependent individual of the exemption program and what it can and can not do.

e. Convince the drug and alcohol dependent person to seek out professional assistance and inform him of the rehabilitation programs available.

f. Convince the supplier to discontinue his involvement in drug abuse.

3. IMPLEMENTATION.

a. General. Drug and alcohol abuse is a complex problem which impacts upon all segments of the Army community. Therefore, to be an effective preventive measure, the Drug and Alcohol Abuse Education and Training Programs must be operated on a decentralized basis to cover every aspect of the respective problem areas. The total program should be tailored to the culture, age, and education of the audience, and it requires positive, credible and innovative command support at all levels. Maximum use of ex-drug dependent personnel and ex-alcohol dependent individuals to assist in all aspects of the educational/training programs is strongly encouraged. Personnel used must be selected with care and properly supervised. The buckshot effect through mass media should be avoided.

b. Requirements. Training requirements are prescribed in AR 600-32 and CONARC messages.

c. General Responsibilities.

(1) HQ CONARC: See Section VII B2.

(2) Major CONARC Commands: Commands will develop programs to provide alcohol and drug abuse education and training for military personnel, dependents, and DA civilians. To assist in the development of comprehensive programs, commanders will:

(a) Insure training and education programs are designed to meet local requirements.

(b) Evaluate the feasibility of establishing Mobile Education Teams. (Annex A - Glossary of Terms)

(c) Make maximum use of their Education Services Advisor/Officer.

(d) Conduct Drug/Alcohol Education Workshops for officers and NCOs as explained in Appendix 2 this annex.

(e) Utilize accredited civilian agencies to assist in development of unit drug and alcohol abuse education training programs provided funds are available. For information concerning civilian agencies and institutions available, contact HQ CONARC (DCSPER-DAACD).

(f) Insure complete interchange of ideas by maximum dissemination of lessons learned.

(g) Insure proper selection, training and utilization of personnel for the Drug Education Specialist Program. See Appendix 1 this annex.

(h) Conduct periodic evaluations of the effectiveness of drug and alcohol abuse education programs for dependents and DA civilians as outlined in paragraph 3d this annex.

(i) Make maximum use of the Alcohol and Drug Dependency Intervention Council (ADDIC) to assist in development of all aspects of training and education programs.

(3) CONARC Service Schools and Army Training Centers.

(a) Under provisions of AR 600-32, all CONARC Schools are responsible to integrate Drug Abuse Training into current programs of instruction.

(b) United States Army Infantry School: Develop Army subject schedules and instructional materials for drug abuse instruction for USATC, NCO Academys and Drill SGT Schools in accordance with CONARC message, DTG 062035Z Aug 71, subject: Drug Abuse Training Proponency (S-1 Dec 71).

(c) United States Army Military Police School: Assigned overall proponency for Drug Abuse Training for Service Schools in accordance with CONARC letter, dated 4 Nov 1970, subject: Drug Abuse Training.

(4) United States Army Personnel Processing Centers: Insure that all personnel returning from overseas and all others processing through personnel centers will be orientated concerning drug abuse prevention and the locations of rehabilitation facilities.

d. Individual Training.

(1) The training packet furnished by the US Army Military Police School will be used as a basic guide for integration of this training into appropriate courses of instruction in CONARC schools.

(2) To acquaint instructors on the subject of Drug Abuse, conferences will be held periodically by USAMPS. On an invitational basis, CONARC Schools and ATCs are encouraged to participate in these conferences insuring that well qualified instructors and/or potential instructors attend.

(3) Basic training programs will reflect two hours "Initial Drug Abuse Orientation". Training will be presented early in the training cycle, preferably before the third week of training.

(4) NCO Academy and Drill Sergeant School programs, will reflect two hours training in "Leadership Aspects of Drug Abuse".

(5) Commanders (commandants) may schedule additional drug abuse training as desired by using Commander's (Commandant's)/Administrative Time.

(6) Drug Education Specialist Program.

e. Unit Training.

(1) Unit training should emphasize the commander's policies; refresh unit individuals on the physiological, psychological, legal, and moral dangers in the abuse of drugs and alcohol; and seek to mobilize peer group pressure against drug and alcohol abuse.

(2) Battalions and separate companies will have a minimum of one Drug Education Specialist (DES). The DES should assist in the organization and development of unit drug abuse education and training activities.

(3) Flexibility, informality, honesty, and depth of knowledge are keys to effective unit drug and alcohol abuse training. Commanders must be imaginative and must design this continuing indoctrination to be responsive to unit alcohol and drug abuse problems.

(4) Discussion group workshops should be conducted as required. The workshops should be of small size with unit integrity being maintained. Discussion leaders must be knowledgeable in drug and alcohol abuse, highly motivated, and capable of developing peer group pressure against drug and alcohol abuse within the unit. The use of ex-addicts and ex-alcoholics, as well as unit Drug Education Specialists, to assist discussion leaders is encouraged.

(5) Maximum use should be made of guest speakers from Alcohol and Drug Dependancy Intervention Councils, local installation and community drug abuse centers, and Alcoholics Anonymous Chapters.

(6) Unit commanders should insure dissemination of information concerning recreational opportunities is made to all personnel in order to provide maximum involvement of personnel in constructive leisure time activities (Special Services; Youth Activities; and Officer, NCO, and EM Wives Clubs, etc.) to insure an integrated and complete recreation program.

f. Community Education Program: The local community plays a major role in the prevention of drug abuse. Members of the community represent a sizable human resource pool which can be tapped readily and inexpensively to deter alcohol and drug abuse.

(1) Dependent Education: The following steps will be taken as a minimum to assure appropriate and positive actions to implement an effective alcohol and drug abuse education program for all military dependents under CONARC control:

(a) Designate a coordinator of Alcohol and Drug Abuse Education in each school. Coordinator will be skillful, know counseling techniques, be able to communicate and relate with children, and have organizational ability so that effective community involvement will result.

(b) Designate a military representative to work with the coordinator to implement an effective Alcohol and Drug Abuse Education Program involving educators, parents, students and others of the military community.

(c) Dependent Military Schools should be encouraged to:

1. Distribute educational materials about drugs.
2. Sponsor social gatherings and meetings which focus on drug abuse prevention and control.

(d) Conduct workshops on alcohol and drug abuse education involving students, parents, educators and the military community.

(e) Military dependent children should be encouraged to:

1. Attend drug education and training courses.

2. Mobilize peer pressure against drug abuse.

3. Have a representative on the ADDIC, subject to command approval.

(f) Dependent schools in areas not under DA control, commanders will coordinate with school authorities concerning integration of alcohol and drug abuse education in the curriculum.

(2) Department of the Army Civilian Employees: The following will be provided as a minimum for civilian employees working within CONARC activities:

(a) Initial alcohol and drug abuse orientation for all new employees.

(b) Education programs and dissemination of educational materials to all civilian employees on dangers of alcohol and drug abuse, including safety hazards.

(c) Training for supervisors in recognition and dealing with alcohol and drug abusers.

(d) Appropriate medical consultation and counseling services when necessary.

4. OTHER COMMUNITY EDUCATIONAL ACTIVITIES. To further total community involvement in the education programs commanders will insure the following additional actions:

a. Commanders should:

(1) Provide settings in which representatives from subordinate elements (such as the NCOs, Enlisted Men's Advisory Councils, Junior Officer Councils, Wives and Dependents) can express their concerns and offer recommendations about alcohol and drug abuse and related matters.

(2) Maintain liaison with health and welfare agencies and alcohol and drug prevention programs in the civilian community.

b. Halfway House - RAP Center should:

(1) Serve as the centralized drug referral and resource agency in the military community and as an informational point for the civilian community.

(2) Provide information and "hot line" service 24 hours a day.

(3) Furnish facilities for "RAP" sessions for Army personnel and their dependents after normal duty hours.

- (4) Have one officer in charge who will:
 - (a) Supervise the Center.
 - (b) Develop and coordinate community preventive efforts, to include resources required in rehabilitative programs.
 - (c) Maintain liaison with health and welfare agencies and drug prevention programs in the civilian community.
 - (d) Be a member of the command Alcohol and Drug Dependency Council (ADDIC).
 - (e) Draw on civilian resources to supplement military programs.
- c. Special Services should:
 - (1) Insure that adequate recreational facilities and equipment are readily available for sports and games.
 - (2) Maintain a regular schedule of social activities and recreational events.
 - (3) Insure that soldiers are made aware of recreational opportunities open to them in the military and civilian communities.
- d. Army Community Services should:
 - (1) Provide information, assistance, and guidance to military families on alcohol and drug related problems.
 - (2) Identify problems related to the community and its needs, especially concerning alcohol and drug abuse, and convey these to the ADDIC.
- e. Army Clubs, to include wives, officers, and enlisted should be encouraged to:
 - (1) Raise money for films for educational programs.
 - (2) Send members to drug abuse training centers and alcoholism prevention and treatment programs.
 - (3) Have representatives on the ADDIC, subject to command approval.
 - (4) Offer volunteer services to drug abuse prevention programs, especially at the RAP Center.

APPENDICES:

- 1-Drug Education Specialist Program
- 2-Drug/Alcohol Education Workshops

APPENDIX 1 (Drug Education Specialist Program) to ANNEX C (Education and Training) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide information and guidance on the establishment and functioning of the Drug Education Specialist Program.

2. GENERAL. DA has directed that battalions and separate companies will have a minimum of one Drug Education Specialist (DES). The primary function of the DES is to assist commanders in the organization and development of unit drug abuse education activities.

3. RESPONSIBILITY.

a. HQ CONARC: Select, procure and issue information materials related to DES Programs to subordinate commands. See Annex G, Information.

b. CONARC Subordinate Commands:

(1) Establish Drug Education Specialist Training Program within respective commands.

(2) Periodically conduct Drug Education Specialist training within commands. The first of such programs should be completed NLT 15 Nov 71.

4. IMPLEMENTATION.

a. Selection criteria:

(1) Selection of personnel for DES Program should be made at unit level to assure command influence over the selection process.

(2) Personal characteristics and qualification prerequisites of personnel selected for DES Program should include as a minimum:

(a) Relatively young, mature individual.

(b) Officer or enlisted.

(c) Some college education in the social or behavioral sciences; or,

(d) Education or practical experience in the drug culture.

(e) Be a capable organizer.

(f) Be able to work with individuals and groups with divergent points of view.

b. Training Program:

(1) The objective of the DES Training Program is to indoctrinate interested and qualified individuals on command Drug Abuse and Alcoholism Programs in order to provide unit commanders with assistance in the organization and development of unit education programs.

(2) Training Program establishment, supervision and management will be a command responsibility.

(3) Commanders should evaluate the feasibility of using the Mobile Education Teams as a source of faculty support for the DES Training Program.

(4) Halfway House/"RAP" Center personnel should be used to support the DES Training Program.

c. Unit Functions of Drug Education Specialist:

(1) Organize and develop unit drug abuse education activities.

(2) May act as a member of ADDIC.

(3) Perform as a discussion group leader during unit alcohol and drug abuse education discussion group opportunities.

(4) Perform liaison duties between unit and Halfway House or "RAP" Center facilities.

(5) Assist commanders in the procurement and distribution of drug abuse information materials.

5. ADMINISTRATION.

a. MOS Authorization:

(1) Personnel selected and trained as a DES will not be awarded an MOS for such training, but will perform the tasks as DES as an additional duty. Commanders should insure that adequate time be allotted to the DES to perform his responsibilities.

APPENDIX 2 (Drug/Alcohol Education Workshops) to ANNEX C (Education and Training) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide information and guidance for the conduct of a Drug/Alcohol Workshop.

2. GENERAL. DA has directed that major subordinate commands conduct Drug/Alcohol Education Workshops for officers and NCOs. The primary objective of such workshops is to insure that senior personnel (officer and NCO) are knowledgeable of all aspects of the drug and alcohol abuse program within their respective commands. Of equal importance, such workshops must make officers and NCOs aware of their role in the over-all implementation of the program.

3. RESPONSIBILITY.

a. HQ CONARC: Develop, procure and issue information materials related to Drug/Alcohol Education Workshops to subordinate commands.

b. CONARC Subordinate Commands:

(1) Establish programs for Drug/Alcohol Education Workshops within respective commands.

(2) Periodically conduct Drug/Alcohol Education Workshops. The first of such workshops to be completed NLT 30 Nov 71.

4. CONDUCT OF WORKSHOPS.

a. Commanders should actively participate in the conduct of Drug/Alcohol Education Workshops.

b. Commanders should evaluate the feasibility of using the Mobile Education Teams to support command workshop activities.

c. "RAP" Center staff personnel should be used to support workshops at lower levels (installation).

d. The following topics should be considered for inclusion into command education workshops:

(1) Leadership role in Drug and Alcohol Abuse Education Training Programs.

(2) Leadership responsibilities in rehabilitation programs.

(3) Command Drug and Alcohol Abuse Prevention and Control Programs.

- (4) Problem areas of Command Drug and Alcohol Abuse Programs.
- (5) Lessons learned within command.
- (6) Commander's guidance.

ANNEX D (Rehabilitation) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To prescribe policy and provide guidance for the identification and rehabilitation of the drug and alcohol abuser.

2. GENERAL.

a. Nature of the Problem:

(1) In its broadest sense, drug and alcohol abuse are environmental problems of a social nature, rather than a specifically medical or psychological problem. To treat the problem in isolation, away from that environment in which the problem developed is an unworkable approach. Although there are physiological consequences associated with drug and alcohol abuse, the real problem lies with individual's inability to cope with the limitations and realities of himself and his environment. If he is to learn to live drug or alcohol free in the real world environment, he must deal with his problem within context of that environment. Thus, the problem is viewed as a community one in which the resources and cooperation of the entire community must be drawn together if rehabilitation is to be successful.

(2) The nature of the spread of drug abuse is such that the presence of a single abuser within the community threatens that community as he introduces to, and involves others with, drugs, or excessive drinking behavior patterns.

b. Effect of Drug and Alcohol Abuse on Unit: The presence of a single alcohol or drug abusing individual has a potentially serious impact on a unit's capacity to accomplish its mission. Areas seriously affected include:

- (1) Security
- (2) Safety
- (3) Unit Performance

c. Role of the Commander:

(1) Given the multifactorial nature of the problem, a multi-disciplinary approach is dictated. Because the unit commander is most affected by the presence of the problem in his unit, and has the most influence over the environment in which the problem occurs, he is therefore the key man to deal with the problem.

(2) The commander bears the key responsibility for the operation of the rehabilitation programs for those individuals in the unit having drug or alcohol problems. He will utilize the services of the MEDDAC, halfway house, rap center, etc., in such a way as to facilitate the rehabilitation of the individual within the unit.

d. Suggested Models: The following are suggested models of how the identification/treatment and rehabilitation portions of this program could operate:

(1) Identification/Treatment:

(a) Situation: A soldier reports to his commander (directly or through the exemption representative) that he has a problem and would like to request exemption.

1. Commander insures that the soldier qualifies for exemption and understands the scope and limitations of exemption.

2. The commander sees that the soldier is taken to the appropriate medical facility for detoxification/treatment and evaluation.

3. Commander requests the personnel at the halfway house to immediately contact the soldier to initiate the rehabilitation process.

(b) Situation: Commander is informed that a soldier in his company has been identified as a drug abuser through urinalysis testing.

1. Commander insures that the soldier is referred to appropriate medical authorities for evaluation and detoxification treatment.

2. Commander contacts the soldier and discusses the situation with him explaining that, while not eligible for exemption, he can enter the rehabilitation program if he desires.

3. If the soldier accepts, the commander initiates rehabilitation process.

4. If the soldier refuses, he either is encouraged to contact the rap center, or, if the circumstances warrant it, the commander proceeds with administrative action. (4b(1), Appendix 3, this annex)

(c) Situation: Commander is informed that the soldier was admitted to the hospital with acute drug abuse complications: Same as (b).

(d) Situation: A soldier requests his commander's assistance because his wife has been taking pills and cannot seem to go without them.

1. Commander explains to the soldier that dependents are entitled to detoxification/treatment and rehabilitation services.

2. Insures the soldier is permitted time to contact rap center and medical personnel and continues to counsel him as he and his wife attempt to solve the problem.

(e) Situation: A civilian under control of commander informs him of his problem:

1. Commander insures that the civilian personnel officer is contacted in order to arrange for rehabilitation/treatment with the appropriate agency.

2. Commander consults with the treating agency for advice on what role he can play in the overall therapeutic program when the civilian returns to work.

(2) Rehabilitation: For most situations involving military personnel, the rehabilitation will be essentially the same.

(a) At an early date, following identification, the commander should meet with medical personnel, rehabilitation personnel, and others as appropriate, to outline what kind of rehabilitation program the subject should have.

(b) The commander sees that the mechanics are set up so that the subject receives all of the rehabilitation inputs needed.


(c) The commander paves the way for acceptance of the subject by his peers when he returns to duty.

(d) The commander maintains contact with rehab personnel to check progress, learn about and solve problems arising during duty, and review the overall program periodically.

(e) The commander may maintain the individual in a rehabilitation program so long as he feels the individual can benefit from it.

(f) If the soldier does not respond to rehabilitative efforts after approximately 60 days he may be declared a rehabilitative failure. In such cases, the soldier can be administratively separated. His commander will insure he is referred to an appropriate civilian agency.

(g) Should the soldier separate through normal ETS channels while undergoing rehabilitation, the commander will insure that he is referred to an appropriate civilian agency.



e. Summary. The commander is the key man in all phases of this program including identification and rehabilitation. The effectiveness of the rehabilitation program is dependent on command emphasis and concern with meeting and solving this difficult, complex and serious problem.

3. OBJECTIVES.

a. Through a combination of biochemical testing and clinical analysis, identify drug and alcohol abusers.

b. As a result of total community involvement, establish an effective process which will insure rehabilitation of those individuals identified as drug or alcohol abusers.

4. IMPLEMENTATION.

a. Identification (Appendix 1)

b. Detoxification/Treatment (Appendix 2)

c. Rehabilitation (Appendix 3)

APPENDICES:

1-Identification

2-Detoxification/Treatment

3-Rehabilitation

APPENDIX 1 (Identification) to ANNEX D (Identification and Rehabilitation)
to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To prescribe policy and provide guidance for the identification of drug and alcohol abusers.

2. IMPLEMENTATION.

a. Medical (Professional)

(1) Objective: To identify by means of periodic biochemical testing and clinical evaluation, personnel who are alcohol dependent or drug users so that appropriate treatment and rehabilitation may be provided.

(2) General:

(a) Biochemical testing is an aid to clinical judgment. Diagnosis will be made by clinicians and not on the basis of test results alone.

(b) Biochemical testing procedures will be modified as further experience is gained in their use and as further technological developments occur.

(c) The basic purpose of identifying alcohol and drug dependent personnel is to provide them with constructive and concerned help for their problem.

(d) Alcohol and drug dependency as a program concept is a state of physical addiction, psychological habituation, or compulsive use.

(e) Distinction must be made between intermittent drug users and drug dependent individuals. Intermittent drug users may have a small psychological problem or none at all, while drug dependent individuals have a major problem requiring vigorous attention. A similar distinction must be made between the problem drinker and the alcohol dependent individual.

(f) While biochemical testing is not feasible for hallucinogens and the more esoteric drugs, all drug abusers will be treated under this plan; the identification of alcoholics and individuals dependent upon hallucinogens will continue to be on the basis of clinical judgment. When so identified they will receive the same high-level concern and care afforded to other drug dependent individuals.

(g) Many alcohol and drug dependent individuals, by virtue of their dependency and their psychological problems, will seek to deceive themselves and others. The identification program must

realistically take cognizance of this fact while at the same time providing a therapeutic atmosphere with expectations of mature behavior.

(h) By means of repeated urine testing it is possible and feasible to distinguish between the intermittent drug user and the drug dependent individual in an environment which is not drug free.

(3) Implementation:

(a) All active duty Army personnel will be subjected to urinalysis testing for the presence of amphetamines, barbiturates and opiates at the following times during their military service;

1. During their first days of active duty service.
2. At least once annually during their service on a "spot check" basis.
3. During the period preceding PCS or separation date, early enough to permit appropriate action prior to individual's scheduled departure and in time to insure that reassignees/separates meet their PCS and separation date, respectively.
4. During the period preceding leave or R&R out of country in the Pacific area and leave back to CONUS in other overseas areas. Emergency leave is excluded.
5. Prior to personnel traveling overseas or departing a country on TDY over 30 days.

(b) The urine specimen will be provided under conditions of direct observation by reliable personnel.

(c) If an individual's urine is found to be positive for amphetamines, barbiturates, or opiates, he will be referred to the adjacent medical facility and evaluated concerning his use of drugs. If it is not demonstrated that he is taking these drugs by prescription under a supervised medical treatment plan, he will be admitted to an appropriate US Army medical facility to determine whether he is an intermittent user or whether he is drug dependent.

(d) Urine testing on PCS does not apply when an individual is reassigned on intra-command PCS for military necessity.

(e) Laboratory Support. TAB A

b. Chaplain Activities

(1) Chaplains have opportunities to identify many drug abusers even before family and friends are aware of the problem. Some first offenders seek out the chaplain because they are aware of his concern for the abuser's spiritual welfare. Others come to the chaplain in desperation after long abuse.

(2) Chaplains will provide maximum opportunity for members and dependents to receive counseling. Privileged communication must be respected.

(3) Maximum effort must be exerted to encourage the drug abusers voluntary request for exemption and submission to treatment.

(4) The chaplain realizes that the alcohol abuser lives with religious strivings, a fear of death, loneliness, and a sense of meaninglessness. Alcohol becomes the value in his life. The chaplain has many opportunities in counseling to identify the problem.

(5) The chaplain should provide maximum opportunities for alcohol abusers to find him. An accepting relationship can lead the alcohol abuser to respond by committing himself to a program of rehabilitation.

c. Legal Aspects

(1) Exemption Program: See Appendix 1, Annex A.

(2) Urinalysis. Para 5-32, AR 600-20 provides that a member may be ordered "to submit to a medical examination when indicated". Such an order would be illegal if the results of such an examination were to be used against the member at a court-martial or proceedings UP Article 15, UCMJ. However, if the results of an examination are only to be used for medical evaluation and treatment, then a refusal to obey it would be a violation of the UCMJ and disciplinary actions under the UCMJ could be taken. The results of chemical analysis will not be used as evidence against the donor at a court-martial or as justification for imposition of punishment UP Article 15, UCMJ.

TAB A - Laboratory Support

TAB A (Laboratory Support) to APPENDIX 1 (Identification to ANNEX D
(Identification and Rehabilitation) to CONARC DRUG ABUSE AND ALCOHOLISM
CONTROL PROGRAM

1. PURPOSE.

a. To describe the nature of laboratory support required from civilian medical laboratories.

b. To establish the program for providing required laboratory support.

2. ASSUMPTION. Civilian laboratory support will be required for a minimum of six months and may be required for an extended period of time.

3. IMPLEMENTATION.

a. Contract laboratory support, using civilian medical laboratories, will be used to accomplish urine testing as outlined in paragraph 2a(3) Appendix 1, Annex D.

b. Contracts have been signed with the following laboratories to conduct urine testing for major commands shown:

(1) 1st and 3d Armies:

Washington Reference Laboratory
4380 MacArthur Boulevard
Washington, D. C. 20007

(2) 5th Army:

United Medical Laboratory
Box 3739
Portland, Oregon 97208

(3) 6th Army:

Biochemical Procedures
12020 Chandler Boulevard
North Hollywood, California 91607

c. Contract laboratories will:

(1) Accept and test urine specimens seven days per week.

(2) Provide specimen container, shipping boxes and labels to each collection point based upon the station forecasted requirements. No more than a two week supply of the foregoing items will be provided. Contractor will defray aforementioned shipping costs.

(3) Provide a point of contact to coordinate actions with stations.

(4) Provide a report to each station within 24 hours after receipt of samples. Report will be by telecommunications and will be confirmed in writing within seven days.

(5) Submit payment statements in accordance with the procedure included in the contract. The US Army Medical Materiel Agency, Phoenixville, Pa., will verify statements and initiate action to pay the laboratories.

(6) Furnish a weekly statistical report to the Contracting Officer or his designated representative. Report will include total number of samples analyzed and the total testing results for each collection point.

(7) Provide instructions to applicable commands on how to code specimens.

d. Estimated daily laboratory testing workload and the maximum examination capacity of laboratories are at 3f, this tab. The maximum daily quota will not be exceeded, without prior approval of DA.

e. Major CONARC commands will:

(1) Manage the laboratory testing program for all personnel within their geographical area, except Class II hospitals or medical centers.

(2) Establish procedures to ensure samples are normally collected and shipped on a regular and continuous basis. Samples will be shipped to the contractor promptly by the most expeditious means of transportation. Objective is for samples to reach supporting laboratory within three days following collection.

(3) Designate a command program coordinator and a station point of contact. Submit names of said individuals to HQ DA DASG-DDL-M. Direct communication between laboratory point of contact and program coordinators/station point of contact is authorized.

(4) Ensure that collected samples are positively identified with the actual donors. Maintain close surveillance of samples to prevent substitution. Patient's name will not be placed on label. Identify specimens by a numerical code.

(5) Maintain records to relate the test results from the contract laboratory report to the individual who provided the specimen.

(6) Fund cost of shipping samples and other program expenses, except those related to commercial laboratory testing. Report the impact of these costs in budget execution review. Submit cost data to HQ CONARC upon request.

(7) Report unresolved problems and requests for modification of assigned daily quota to HQ CONARC ATPER-MED.

f. Capacities of civilian laboratories:

<u>Army</u>	<u>Desired 1/</u>	<u>Maximum</u>
First Army (Includes MDW)	607	1214
Third Army	613	1226
Fifth Army	584	1168
Sixth Army	<u>693</u>	<u>1386</u>
Total	2497	4994

1/ Desired is the preferred number of samples submitted daily to satisfy the testing requirements.

APPENDIX 2 (Detoxification/Treatment) to ANNEX D (Identification and Rehabilitation) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To prescribe procedures for the administrative and medical handling of personnel identified as drug users and the detoxification of drug dependent individuals, including alcoholics.

2. IMPLEMENTATION.

a. Medical

(1) General:

(a) "Drug dependency" describes the medical and psychiatric, or disease aspects of the social phenomenon, "drug abuse". Understanding the interaction of medical and social variables makes successful treatment possible for both drug dependency and alcoholism.

(b) Individuals vary in their susceptibility to drug dependency and alcoholism.

(c) Alcoholism and drug dependency produce longlasting alterations in body chemistry which may diminish physical capacity for personal responsibility. (e.g., delirium tremens of alcoholism, coma of heroin overdoses.)

(d) Alcoholism and drug dependency are largely psychological phenomena, although metabolic and genetic factors play a part.

(e) The cure for drug and alcohol abuse lies in a changed relationship between the individual and society. Use of medications, however, can help the drug dependent or alcoholic individual to function better.

(f) Regardless of the circumstances, alcoholism and drug dependency are, in part, ways of life chosen by the individual. Successful treatment must enhance the individual's capacity to take responsibility for himself. Excusing him from major military duties may reward the individual for his drug-taking, but, just punishing him is ineffective.

(2) Implementation:

(a) During the initial period of inpatient observation, the individual will have a daily interview with a trained AMEDD specialist. Men suspected of drug dependency will have their urine tested daily.

(b) If during this period of observation it is determined that the individual is an intermittent drug user and not dependent (or problem drinker and not alcoholic), he will be counseled by trained medical personnel concerning his use of drugs. Such counseling will include as a minimum:

1. Individual instruction as to the dangers of drug and alcohol usage.

2. Exploration with the individual of current stresses in his life and means which might be taken to ameliorate them.

3. Individual instruction as to the availability of drug abuse or alcoholism programs and other relevant helping resources in the military or civilian communities, whichever is appropriate.

4. Referral, when indicated, to other medical and nonmedical agencies, such as mental hygiene for psychotherapy, Chaplain for spiritual guidance, or Army Community Service (ACS) for financial counseling.

(c) After determination is made that the individual is an intermittent user and not drug dependent, and he has been counseled, the period of inpatient observation will cease. He will be discharged from inpatient observation with the diagnosis "Improper Use of Drugs (specific drug)".

(d) As soon as an individual is identified to be drug dependent, either by history, clinical observation, or the onset of withdrawal symptoms, he will undergo detoxification.

(e) Individuals voluntarily seeking treatment for alcoholism or for drug dependency under the Exemption Program will be treated in the same manner as if they had been identified as drug dependent by biochemical testing or by their overt clinical symptomatology.

(f) If the individual is identified as a drug user at the time of departure for separation or PCS (DEROS) from an assignment in the US Army, Pacific, he will be medically evacuated from that country to one of 34 CONUS medical facilities listed at 2a(5)(e), this appendix. If such an individual has a PCS assignment, he will be evacuated to the facility which is nearest his post of assignment. If the individual is departing a foreign country to meet his ETS, he will be evacuated to that medical facility closest to his home of record. As a minimum, those individuals identified as drug dependent will be medically evacuated from other overseas areas.

(g) Patients will not be released for medevac as long as their daily urine tests show traces of illicit drugs. In exceptional cases, where drug usage is unusually severe and when such treatment is indicated by the medical officer, patients may be placed on maintenance medications. Medical evacuation from overseas will not be rushed when such haste might jeopardize the patient's health, quality, or continuity of care.

(h) Detoxification will be accomplished when considered necessary in the judgment of the attending physician. Usually up to seven days of inpatient care will be provided. Methadone may be used to ease the discomfort of rapid withdrawal from a state of opiate addiction, but in no case will it be used for maintenance therapy, except to maintain health during aeromedical evacuation. Outpatient use of drug antagonists is to be in accordance with Food and Drug Administration (FDA) regulations.

(i) The MEDDAC Commander will refer drug dependent personnel who are about to be separated from the Army, to VA or civilian rehabilitation programs and facilities. Successful referral means transferring the soldier into a VA hospital. If VA does not have space available, or the soldier expresses a strong preference he should be referred to an established civilian rehabilitation program near his community, by arranging and verifying the date, place and time of his initial appointment in that program. It is recognized that due to the exigencies of time, marginal patient motivation and limited civilian resources, adequate referral may not be made prior to ETS, but all possible effort will be made to meet the goal. Transition program personnel will be utilized to the maximum extent possible to aid in this effort. Authorities responsible for this aspect of the program will familiarize themselves with all the civilian rehabilitation programs and facilities operational in the geographical area served by the MEDDAC. HQ DA will distribute periodically lists of VA and civilian drug treatment facilities.

(j) Drug dependent personnel awaiting separation without a unit of assignment and drug dependent personnel identified at the reception station will be continued on an inpatient status until separation or EPTS medical discharge is accomplished. During this period of time, they will be provided with group therapy, occupational therapy and recreational therapy services as a minimum. Identification of civilian sources for rehabilitation should be sought for those identified as drug dependent at reception stations. Personnel so identified should be referred to the sources indicated but separated under appropriate Army regulations prior to their departure from the military activity.

(k) Drug dependent personnel will receive a complete medical examination, including psychiatric consultation. Those found to be suffering from a medical condition, such as schizophrenia, chronic brain syndrome or chronic cirrhosis, which renders the member medically unfit for retention in the Service, will be processed in accordance with AR 635-40.

(l) Active duty Army drug dependent personnel, excluding only those identified at the reception centers and those suffering from medical conditions which warrant medical discharge from the Service, with more than 60 days remaining in Service, will be discharged from inpatient status to duty to begin rehabilitation as rapidly as possible,

consistent with good medical practice. This dictates that prior to discharge, the patient will be in good physical health, completely withdrawn from physical dependence on all drugs, and have established a direct contact with a sponsor from his duty unit of assignment who will either be the organization commander or his designated representative. Regardless of the apparent motivation of the patient, the duty unit of assignment will be a unit in consonance with his MOS and grade, whenever possible.

(3) Laboratory Procedures:

(a) See TAB A, Appendix 1, Annex D.

(b) During detoxification, all individuals will have a daily urine test for amphetamines, barbiturates and opiates.

(c) Urine test results will be provided within a 24 hour period during this phase.

(4) Medical Logistics:

(a) Objective: To establish a program for CONARC wide medical materiel support of detoxification on a continuing basis.

(b) Implementation:

1. Detoxification requires the establishment of centers for personnel identified as abusers of amphetamines, barbiturates, opiates and alcohol.

2. Requirements for methadone HCl, nalorphine HCl, disulfiram, and other drugs, will be submitted through normal supply channels. They will bear the appropriate high priority, provide for shipment by air and include Project Code MSI. The US Army Medical Materiel Agency will accept these requisitions for intensive management. After coordination with the Logistics and Facilities Division, OTSG, immediate, continuing action will be taken to supply or procure the requirements.

3. Initially, methadone HCl and nalorphine HCl will be obtained by local procurement from commercial sources within CONUS.

4. Action will be taken by the Chief, Logistics and Facilities Division, OTSG, to type, classify and stock methadone within the Defense Supply System.

5. Army units are authorized to utilize all available stocks to support this program. War reserve stocks utilized must be replaced expeditiously.

6. A record of operations and maintenance costs applicable to detoxification will be maintained by all participating agencies and will be provided to the Office of The Surgeon General upon request.

7. Requests for logistics assistance will be directed to the Supply Officer, Office of Surgeon, CONARC, Ft Monroe, Va 23351.

(5) Patient Administration and Biostatistics:

(a) Objective: To provide medical administrative procedures for the AMEDD reporting of all military members admitted as a result of confirmed positive identification as alcoholics or drug users.

(b) General:

1. There will be a continuing requirement to follow trends in alcohol and drug abuse and to provide biostatistical data to Army staff agencies on a need-to-know basis.

2. Alcoholics and drug users or drug dependent individuals will be attached to a medical holding unit while an inpatient in a Medical Treatment Facility (MTF) until detoxification or other medical treatment is completed and the patient is returned to duty or enters the rehabilitation program.

3. Members identified as problem drinkers or drug users will be counseled prior to release from inpatient status.

(c) Concept:

1. Possible diagnoses: Improper use of drugs. This term will be used for the member, not addicted to or dependent upon drugs, who has been admitted for observation because of the effects of improper use of drugs and in whom no other diagnosis is determined to be more appropriate. It will not be used in place of a diagnosis of drug dependence, or acute poisoning by drugs. When this term is used, the name of the known or suspected drug will be specified.

2. Instructions for statistical classification and coding DA Form 3648 (Coding Transcript - Individual Patient Data System) from each Clinical Record Cover Sheet or US Field Medical Card which reflect one of the diagnoses above, are as follows:

a. Improper use of drugs (specify drug) will be coded in accordance with Change 2, Paragraph 3-91b, AR 40-400, utilizing "793" and an appropriate alphabetic designator applicable to the specific drug.

b. "Drug dependence" will be coded in accordance with International Classification of Diseases, Adapted for Use in the United States (ICDA-8).

(d) Implementation:

1. The unit commander will insure that the member whose urinalysis is positive is immediately taken to the nearest US Army MTF for evaluation and admission as a patient. Commands provided primary medical treatment by another service, such as ARADCOM, will ensure that said personnel are taken to the supporting service MTF.

2. The Medical Treatment Facility will prepare, maintain, use, and control medical records for each patient admitted.

3. Members who are verified as drug dependent will be retained in an inpatient status until detoxification is complete.

4. An Army member in CONUS identified as requiring rehabilitation, not due for separation from service for any reason within 60 days, will be returned to duty and appropriate personnel notified of his release.

5. Army members in CONUS identified as requiring rehabilitation and due for separation within seven days will be counseled, detoxified and reported to ASMRO for regulation to a VA hospital.

6. The Line of Duty (LD) entry for a diagnosis "793-" or "304-" will be LD-No, due to own misconduct (NLD:DOM) for that period of time the member is unable to perform normal duty.

7. A copy of the Admissions and Disposition (AAD) Report, reflecting final disposition from inpatient status, will be annotated to reflect the number of days of "bad time", citing Section 10315, DOD Pay and Entitlement Manual, whenever a member has had the primary diagnosis of "793-" or "304-", or "303". A copy of the annotated AAD Report will be forwarded the member's unit commander for appropriate morning report action.

8. Individuals having less than 60 days of active service remaining on an original or adjusted period of enlistment, or obligation, upon arrival at one of the CONUS rehabilitation hospitals, will be reported to ASMRO for regulation to a VA hospital as soon as the need can be determined that the individual requires continuing treatment or rehabilitation. Individuals transferred to a VA facility solely because of drug problems will be separated from active duty, regardless of any voluntary retention, as follows: If ETS, or early separation date, is less than 15 days after transfer, on separation date or as soon thereafter as possible; if ETS, or early separation date, is 15 days or more after transfer, separate on the 15th day following transfer, or as soon thereafter as possible.

9. This plan may be cited as authority for retention on active service for the purpose of receiving medical treatment under this program, regardless of para 2-6, AR 635-200.

10. This plan may be cited as authority for waiver of time lost for purposes of separating individuals UP Para 5-3, AR 635-200.

11. ASMRO will consolidate requests for patients to be transferred to the VA from US Medical Treatment Facilities on a daily basis and telephone these requests to the VA and request a bed site.

12. For reporting requirements, see DA message 061417Z Aug 71, subject: Interim Change to AR 40-400 (C3).

(e) The following CONUS hospitals can accept drug dependent personnel for treatment and rehabilitation:

1. DeWitt Army Hospital, Fort Belvoir, Virginia
2. Ireland Army Hospital, Fort Knox, Kentucky
3. Kenner Army Hospital, Fort Lee, Virginia
4. Kimbrough Army Hospital, Fort Meade, Maryland
5. McDonald Army Hospital, Fort Eustis, Virginia
6. Patterson Army Hospital, Fort Monmouth, New Jersey.
7. United States Hospital, Fort Devens, Massachusetts
8. Walson Army Hospital, Fort Dix, New Jersey
9. Lyster Army Hospital, Fort Rucker, Alabama
10. Martin Army Hospital, Fort Benning, Georgia
11. Noble Army Hospital, Fort McClellan, Alabama
12. United States Army Hospital, Fort Campbell, Kentucky
13. United States Army Hospital, Fort Gordon, Georgia
14. United States Army Hospital, Fort Jackson, South Carolina
15. United States Army Hospital, Fort Stewart, Georgia
16. United States Army Hospital, Redstone Arsenal, Alabama
17. Womack Army Hospital, Fort Bragg, North Carolina
18. Darnall Army Hospital, Fort Hood, Texas
19. Reynolds Army Hospital, Fort Sill, Oklahoma
20. United States Army Hospital, Fort Polk, Louisiana

21. General Leonard Wood Army Hospital, Fort Leonard Wood, Missouri
22. Munson Army Hospital, Fort Leavenworth, Kansas
23. Irwin Army Hospital, Fort Riley, Kansas
24. United States Army Hospital, Fort Carson, Colorado
25. Raymond W. Bliss Army Hospital, Fort Huachuca, Arizona
26. United States Army Hospital, Fort Ord, California
27. Brooke General Hospital, Texas
28. Fitzsimmons General Hospital, Colorado
29. Letterman General Hospital, California
30. Madigan General Hospital, Washington (State)
31. Walter Reed General Hospital, Washington, D. C.
32. William Beaumont General Hospital, Texas
33. Valley Forge General Hospital, Phoenixville, Pennsylvania
34. United States Army Hospital, Sandia Base, New Mexico

b. Personnel Management and Services

(1) The following personnel actions will be taken on those personnel undergoing detoxification/treatment:

(a) Flagging action will be initiated in accordance with AR 600-31 and will be maintained until the individual is released from an inpatient status. At that time, dependent upon the medical determination made during the detoxification period regarding the individual's classification as either a user or as drug dependent, his demonstrated cooperation with the rehabilitative efforts and his total previous character of service, the commander will make a decision to remove or maintain the flagging action. Assignments will be made in accordance with the provisions of paragraph 6b, AR 600-31.

(b) Assignment of a temporary medical profile S-2. After an appropriate rehabilitation period based on individual needs, a decision regarding the revocation of the temporary profile S-2 will be made.

(c) In the interest of national security, action must be taken UP AR 604-5 to suspend an individual's access to classified information when he is found to be a drug abuser. The suspension of an individual's access under this condition is a non-derogatory administrative action designed to protect classified information. Disposition of each case of drug abuse should be based on an overall common sense evaluation.

(d) Line of duty determination will be made.

1. The provisions of Chapter 5, AR 600-10 requiring formal LD investigation involving intemperate use of drugs are amended for those personnel volunteering for treatment under the Alcohol and Drug Abuse Prevention and Control Program. The time spent as an inpatient during the detoxification phase will be classified as NOT IN LINE OF DUTY - DUE TO OWN MISCONDUCT. It is sufficient to annotate the Admission and Disposition (A&D) report and forward to the unit commander for Morning Report entry purposes, and to the custodian of the individual's Financial Data Records Folder (FDRF).

2. This procedure precludes necessity for completion and forwarding through channels of DD Form 261 and DA Form 2173 by medical, company, and other administrative personnel for eventual permanent filing in the individual's personnel file (OMPF). Requirement still exists for formal LD for the following:

a. Injuries or diseases incurred while under drug influence.

b. Personnel who have not volunteered for treatment or who were identified as users but not under the provisions of the Alcohol and Drug Abuse Prevention and Control Program.

c. Personnel who initially wish to appeal LD finding.

3. Pay and Entitlement: As a result of the determination of LD NO - DUE TO OWN MISCONDUCT, the time spent in the detoxification phase of treatment, will be considered as lost time. Under the provisions of DOD Military Pay and Allowances Entitlements Manual, lost time, as a result of the intemperate use of drugs, causes the individual to lose all pay (basic, special, incentive) but he is entitled to allowances. For the period of hospitalization after the expiration of term of service, the individual is not entitled to either pay or allowances.

(2) Soldiers determined to be non-drug dependent (users) will receive counseling while undergoing observation and detoxification, after which the individual will return to, and continue normal duties.

(3) Individuals determined to be drug dependent will also complete detoxification treatment in a hospital or similar facility. Detoxification treatment will last from 2-7 days depending upon the severity

of the dependency. Once released from inpatient status, individuals due to be discharged, may volunteer for additional treatment through Army facilities irrespective of Expiration of Term of Service (ETS). This treatment may be for up to 30 days, however, it is desirable that the patient be referred to a VA or appropriate civilian agency where long term treatment can be provided. A request for retention beyond ETS will be in accordance with AR 635-200; in no case will an individual be involuntarily retained past his ETS. In the case of the soldier due reassignment, he will be placed in a unit consistent with his MOS and grade, whenever possible, and receive outpatient care at his new duty station.

(4) Losing commands will notify gaining commands by message of identified users. Identified drug users should be contacted and offered assistance shortly after their arrival and their acceptance or refusal should be made a matter of record to provide a basis for program evaluation later.

(5) Assignment/Reassignment

(a) Reception Stations: Enlistees and inductees reporting for duty at US Army Reception Stations will undergo urinalysis testing. Individuals entering active duty but not processing through a Reception Station will receive a urinalysis screening at their first duty station. Those individuals determined to be confirmed positive will be referred to detoxification for further medical treatment and observation.

1. Individuals determined to be intermittent users or experimenters (users) will proceed to or continue in unit assignments after detoxification.

2. Individuals determined to be drug dependent will be discharged under the provisions of paragraph 5-9, AR 635-200 and Chapter 16, AR 635-120. The individual does not meet procurement criteria in accordance with Chapter 2, AR 40-501 and possesses a medically disabling condition which existed prior to entering service (EPTS).

(b) Annual Screening (not on PCS or separation orders): While in the detoxification phase the individual will remain in his present morning report status and will be carried attached for treatment as an inpatient at the supporting medical facility. A medical determination will be made classifying the individual as either an intermittent user or drug dependent.

1. User. No change of assignment or personnel action required except for annotation of personnel records in accordance with AR 600-200 reflecting time spent in the medical facility. Line of duty (LD) processing will be in accordance with paragraph 2b(1)(d). After release from inpatient status no change in profile is required.

2. Drug Dependent. After release from inpatient status no change in assignment is required. Individual will return to duty status in original unit. Commander may, on a temporary basis, suspend the individual from flight status. During outpatient rehabilitation, the individual will be carried as part of his normal unit strength figures. After approximately 60 days of rehabilitative treatment, the individual may be recommended for additional treatment, revert to an S-1 profile and restoration to full duties, or be referred for appropriate separation under current regulations. Separation procedures are indicated in paragraph 7b(1), Appendix 3, Annex D.

(c) During period preceding PCS (overseas), separation or TDY.

1. PCS - CONUS to overseas station:

a. User. Continue normal processing after observation or detoxification treatment. Port call date may have to be adjusted if treatment period affects movement dates.

b. Drug Dependent. Individual will not be sent to any overseas station while in this status. Personnel action as per paragraph 2b(1) above will be initiated. Additionally, deletion from overseas movement in accordance with DA Circular 614-18, as amended by DA message 081319Z May 1970, will be accomplished; individual's Foreign Service Availability (FESA) Code will also be changed. When the individual is released from the rehabilitation phase and reassigned an S-1 profile, he is available for world-wide unrestricted assignment. Individual will be reported as immediately available for reassignment under provisions of Chapter 8, AR 614-200.

2. PCS - Overseas station to CONUS:

a. User. Same as paragraph 2b(5)(c)1a above. Counseling and referral assistance will be provided at the CONUS ports of entry prior to individual's departure from the United States Army Personnel Center (USARPERCEN) for leave or next duty station. This counseling and assistance should include no less than the following:

- (1) Dangers of drug abuse.
- (2) Location and availability of treatment facilities at processing centers, and an offer to assist the user in making an appointment.
- (3) Location and availability of military treatment facilities near the reassignee's leave address and at his next duty station, and an offer to assist in making an appointment at these facilities.

b. Drug Dependent. Individual will be medically evacuated, after detoxification, to a CONUS hospital with a rehabilitation capability, to continue detoxification, as required, and rehabilitation treatment.

The losing major command will notify the Office of Personnel Operations (OPO) by submission of appropriate deletion card. Commanders of the installation on which the hospital is located will review the orders of arriving drug dependent MEDEVAC patients to determine if previously issued (post inpatients) assignments are to units on their installations. In this case, unit of assignment may be changed locally as commanders desire. When dependents are involved, commands will provide the appropriate assistance to return the dependents to CONUS.

(1) Enlisted Personnel. If the assignment is to a unit not located on the installation where inpatient care was received, if the individual does not have assignment instructions, or if an assignment is not known, installation commanders will issue orders assigning enlisted patients to units of their selection on their installations upon completion of the inpatient phase. Approval of such assignment action by higher headquarters is not required; however, appropriate branches in OPO-EPD, HQ DA, will be informed when personnel are so diverted. In the event the individual cannot be assigned to the same installation providing inpatient care, assignment instructions will be requested in accordance with Chapter 8, AR 614-200. Commanders of installations on which are located the hospitals supporting this program and to which patients will be regulated will take the following actions:

(a) Review the orders of arriving patients in this program to verify that their previously issued assignments are to units on their installations. Unit of assignment may be changed locally as commanders desire. If the assignment is to another installation, if the individual does not have an assignment, or if the assignment is unknown, within seven days after admission to the hospital, the installation commander will select a unit on his installation and assign the patient to that unit upon release from inpatient status.

(b) Inform appropriate branches in OPO, DA (EPD) of personnel diverted. The losing organizations and Headquarters, CONARC (ATTN: DCSPER MPO-EO), will be information addressees on the diversion messages, which will be in the following format:

Name

Rank

MOS

SSAN

OPO Control and Line Number of original assignment

Authority: CONARC message ATPER-MPO-EO 252029Z Jun 71 (U), subject: Drug Abuse Counter Offensive.

(2) Officer Personnel. Upon release from inpatient status, call the appropriate career branch of OPO-OD for assignment instructions.

NOTE: An exception to this policy is applicable to Vietnam as follows:

All personnel returning from Vietnam who are identified as "confirmed positives" (no further determination will be made) will be returned to CONUS via aeromedical evacuation channels. Assignment of these personnel will be in accordance with the provisions of paragraph 2b(5)(c)2b above.

3. Separation - Overseas station to CONUS:

a. User. Same as paragraph 2b(5)(c)2a above. Counseling and referral assistance at US Army Personnel Center will include the location and availability of Veterans Administration and other civilian facilities near the separatee's home of record.

b. Drug Dependent. The individual determined to be drug dependent will be returned to CONUS for treatment per procedures outlined in accordance with paragraph 2b(4)(c)2b above. Individual will not be separated while in an inpatient status (detoxification). When medical determination is made to release the individual from patient status, an adjusted ETS is computed based on the amount of days lost while in LD "no" category during detoxification. Under the current overseas returnee (early release) policy, individuals are still eligible for separation upon return to CONUS, regardless of the aforementioned LD adjustment to the ETS date. Personnel may request additional treatment beyond their ETS date; the appropriate affidavit will be submitted and processed in accordance with paragraph 2-6 AR, 635-200. Personnel identified for discharge under conditions other than honorable, and not related to their drug dependency, will be afforded the same treatment as all other personnel. Additionally, they may avail themselves of the 30 day extension for drug treatment. Discharge procedures are covered in paragraph 7b(1), Appendix 3, Annex D. While an inpatient, the individual will be assigned to the medical holding detachment. After release, he will be transferred to the installation AG Separation Activity for discharge. If on a 30 day extension past ETS, the installation commander will make a determination regarding unit assignment.

4. Separation - CONUS - Procedures will be the same as procedures outlined above except the individual will be attached for treatment at the supporting medical facility during detoxification and if he requests a 30 day extension, he will return to his unit assignment.

5. TDY - CONUS or oversea station:

a. User. Same as paragraph 2b(5)(c)1a and 2b(5)(c)2a above.

b. Drug Dependent. Same as paragraph 2b(5)(c)1b and 2b(5)(c)2b above. If individual's home station is in CONUS and it has a rehabilitation capability, he will be sent to that location. If not, he will be sent to the hospital nearest his home station with a rehabilitation capability. If home station is in an overseas location, he will be sent to a CONUS hospital as outlined above. The command that the individual is departing will notify the parent unit of his status in the drug program. The parent unit will immediately request assignment instructions in accordance with procedures outlined in Chapter 8, AR 614-200.

(d) Personnel returned to military control (RMC) from an unauthorized absence.

1. Those personnel RMC to their parent installation, drug/alcohol abuser or not, will be assigned to their former unit IAW AR 630-10 and CON Reg 600-2. Under no circumstances will this category of personnel be assigned to a Personnel Control Facility (PCF). The unit commanders will immediately refer individuals identified as drug abusers to medical authorities for detoxification.

2. Those personnel returned to military control at other than their parent installations will be assigned to a PCF (if one is located on the installation) and referred immediately to medical authorities for detoxification. Upon clearance from the medical authorities and disposition of the unauthorized absence, the CONUSA will direct an intra-Army assignment to an installation that can provide follow-up medical care and make use of the individual. In the case of personnel RMC from or en route to overseas units, the installation PCF will request assignment instructions from DA in accordance with Chapter 8, AR 614-200.

(e) Personnel from overseas units, on leave in CONUS. Such personnel identified as drug abusers will be attached to the nearest hospital having capability to treat drug patients. Upon completion of detoxification, the hospital commander will request assignment instructions from OPO-EPD or OPD and make a medical recommendation concerning return to the overseas command.

(f) Personnel undergoing treatment in an inpatient status beyond 90 days will be reassigned to the hospital providing the treatment.

c. Legal Aspects

- (1) Involuntary Hospitalization. A military member who refuses to submit to medical treatment, or diagnostic procedure will be examined by a medical board. The board must decide whether the patient needs the treatment in order to properly perform his military duties and whether the treatment can normally be expected to produce the desired results. If the decision on both points is affirmative, the person will be so advised. If he still refuses, disciplinary action may be taken UP UCMJ.

However, if the emergency treatment, or diagnostic procedure, is required to preserve the health or life of the patient, it may be performed with or without his permission.

(2) Line of Duty Determinations. The problem of LOD determination and extension of enlistment for hospitalization is of utmost importance. A determination of not in LOD will involuntarily extend the enlistment. In the case of officers, there is no such authority to extend the Date of Separation (DOS). During the period the member is unable to perform his duties, after a finding of LOD "no", he will not be entitled to pay but will be entitled to allowances. LOD determinations must be expedited for there is no authority to hold members past ETS or DOS pending the determination.

APPENDIX 3 (Rehabilitation Program) to ANNEX D (Rehabilitation) to
CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide policy and procedures for the conduct of a command oriented rehabilitation program for those personnel who are identified as alcohol or drug abusers.

2. IMPLEMENTATION.

a. Rehabilitation of the alcohol or drug dependent individual continues after he is discharged from the hospital to his unit.

b. The unit commander is primarily responsible for assisting the individual in rehabilitation. The commander should seek the active assistance of alcohol and drug rehabilitation personnel.

c. The administrative responsibility for the alcohol and drug rehabilitation service in CONUS will include but not be limited to:

(1) Group counselling and therapy provided under direction of appropriate personnel.

(2) The provision, when indicated by professional judgment, of Halfway House services. While it is anticipated that many individuals may be discharged outright from the hospital to their unit, it is also anticipated that a number will need a more gradual transition to non-sponsored social activity within their units. In some cases, even following complete discharge to his organization, it may be determined that the individual is not effectively ready for unsponsored social activity. In these cases the individual may be directed to the Halfway House program. In this program the individual will spend his duty hours in the company, but his off-duty hours in the Halfway House, with the exception of passes granted by the Halfway House staff in conjunction with his unit leadership. The Halfway House, staffed with AMEDDS and related personnel, will provide simple housing arrangements and structured activities during non-duty hours to include group recreation, occupational therapy and individual counseling as required.

(3) Intensive work, primarily by behavioral science personnel, with the individual's unit commander, first sergeant, other leadership and peerage to assist the company in responding to the individual's needs in a realistic but flexible, imaginative and supportive manner. This is a most essential part of the program, since the rehabilitation process must be integrated with the soldier's everyday life and will succeed or fail depending upon the quality of relationship between him and his immediate community.

(4) Other modalities of rehabilitation therapy may be provided, as considered appropriate by the alcohol and drug rehabilitation personnel, such as individual psychotherapy, family therapy, psychodrama

and pharmacotherapy with non-addictive psychotropic agents and with drug antagonists according to Federal Food and Drug Administration regulations.

(5) Normally, the decision as to the success or failure of rehabilitation will not be made until the individual has been in his unit for about sixty days. During this period, while he may be allowed passes, he should not ordinarily be granted leave.

(6) During the rehabilitation process the drug dependent individual will be monitored by urine testing, normally twice weekly. No drug dependent individuals will be considered a rehabilitation success until they have had at least eight consecutive negative urine tests.

(7) The decision that an individual is a rehabilitation failure will be made by the unit commander in consultation with the AMEDD officer (MC or MSC) responsible for the supervision of his medical care. If the individual has not been rehabilitated, as evidenced by continued positive urines and/or other evidence, but in the judgment of the AMEDD officer has been treated by his ostracism or undue hostility or other lack of support, then sufficient rehabilitative effort cannot be said to have occurred, and the man will not be judged a rehabilitation failure. Similarly, if the unit commander feels that the individual by virtue of his unit performance possesses rehabilitation potential, this judgment will overcome any medical judgment that he is not rehabilitatable.

(8) Success or failure of rehabilitation will not be judged on the basis of biochemical testing alone. In some cases there is no clear end-point to determine that rehabilitation has or has not occurred. In such cases occasional relapses or "chipping" may be noted, representative of the relapsing nature of most alcohol and drug abuse. Therefore, the judgment of "rehabilitation failure" will be made not on the basis of absolutes such as "cure", but on the basis of estimated potential for further and continuing improvement. The rehabilitative effort is not to be construed as necessarily limited to sixty days. Similarly, if an individual judged to be a rehabilitative success months or years later is again identified as a drug dependent, he should not necessarily be judged a rehabilitative failure without new rehabilitation efforts being made.

(9) During the first sixty days of rehabilitation the individual will be assigned an S-2 temporary medical profile. The meaning of this profile is that the individual is known to have emotional and attitudinal problems which may compromise his judgment or reliability. He may be denied a security clearance, participation in the human reliability program or flight status. In spite of such administrative actions,

every attempt should be made to assign the man in consonance with his MOS. When deemed appropriate by AMEDD authorities and eight consecutive urines have been "clear", the individual's profile may be revised to S-1. The meaning of an S-1 profile is that the individual is judged to be emotionally stable and medically qualified for full duty in so far as his drug use is concerned. In cases where the drug dependent individual has been given such clearance, his commander may, as deemed necessary, require from AMEDD spot checks on the person's urine.

(10) If an individual is judged to be a rehabilitation failure after about sixty days or rehabilitative effort, and if he is not facing criminal prosecution for offenses other than alcohol abuse, drug use and/or drug possession for personal use, he will then be referred to a VA or civilian rehabilitation program. Separation under appropriate Army regulations will be accomplished.

(11) The appropriate commander will inform the specific VA facility of the name of any Army member referred to it so that the facility may offer assistance to the individual.

d. Commanders are strongly advised to place primary reliance for rehabilitation of alcohol dependent personnel on local Alcoholic Anonymous (AA) Chapters. The AA should be encouraged to establish working chapters on the installation and be provided maximum support in the conduct of their program.

e. Rehabilitation Facilities - TAB A, this appendix.

f. Laboratory Procedures - TAB A to Appendix 1, Annex D.

g. Patient Administration and Biostatistics: See DA Message 061417Z August 1971, subject: Interim Change to AR 40-400 (C3).

h. Medical Logistics:

(1) Objectives: To determine the medical materiel and facilities support for rehabilitation within CONARC.

(2) Implementation:

(a) Drugs and other medical materiel required for rehabilitation will be obtained from normal supply sources. Initially, Nalorphine HCl and Methadone HCl will be obtained by local procurement from commercial sources.

(b) Laboratory requirements include eight tests per month for each person included in the program. Initially, laboratory support will be provided by the utilization of commercial medical laboratories. Contracts signed to meet testing and identification requirements will

include sufficient laboratory testing capability to support rehabilitation.

(c) Equipment required to support medical rehabilitation facilities will be obtained from local sources, including Prepositioned War Reserve Stock (PWRS). If required, PWRS will be transferred and accounted for as inventory temporarily in use in accordance with AR 37-111. In the event additional equipment is necessary, requirements will be submitted to the Logistics and Facilities Division, OTSG, in accordance with Medical Equipment Program Reporting System (MEPRS). All requirements will be categorized as emergency and will be submitted by the most rapid means of communication. Class II Medical installations will submit requirements directly to the OTSG. Class I Medical installations will submit requirements through the appropriate Army Headquarters and CONARC.

(d) All CONUS resupply requisitions will continue to be submitted directly to the Defense Personnel Support Center. They will bear the appropriate priority, provide for shipment by rapid transportation methods and include Project Code MSI. The US Army Medical Materiel Agency, upon request for assistance from a medical facility, will provide 24 hour per day service to expedite processing and shipment of materiel.

3. CHAPLAIN ACTIVITIES.

a. Chaplains will be a primary member of drug abuse teams and other control efforts. The office and knowledge of the chaplain must always be available. This is a people problem involving man and his entire sense of values. Lasting results will come when we help the individual discover values and systems of meaning which he can accept.

b. The chaplain should be aware of every possible agency that may be of help. This should include thorough investigation of all religious groups who claim success in rehabilitating drug and alcohol abusers.

c. Most of the problems which trouble and confuse the drug and alcohol abuser are questions about life and its meaning. Therefore, the religious approach is often not only most practical, but most successful in rehabilitation.

d. Emphasis will be given to educating all personnel to the dangers of alcoholism. The church school, worship services, adult and youth groups and unit training are educational opportunities.

e. The chaplain should work closely with local Alcoholics Anonymous chapters. If a chapter on post is needed the chaplain should give his support.

f. A relationship which provides acceptance and mediates the grace of God can begin to meet the dependency needs of the drug and alcohol abuser. A chaplain can provide this.

g. The chaplain is a primary member of any group involved in rehabilitation. He must use wisely and with dedication the tremendous potential for change which he and his office represents.

4. PERSONNEL MANAGEMENT AND SERVICES.

a. Personnel:

(1) Prerequisites for selection of personnel for "rap" centers is continued in TAB A, this appendix.

(2) Drug Abuse Prevention and Control Teams is at TAB B, this appendix.

(3) Assignment and Reassignments for Drug and Alcohol Abusers - See 2b(4) Appendix 2, Annex D.

b. Personnel Management:

(1) Discharge Procedures: AR 635-100 (officer) and AR 635-212 (enlisted) are the basic documents governing all discharges under this plan prior to expiration of term of service (ETS).

(a) If the individual has been afforded adequate treatment and opportunity for rehabilitation, and it is determined that he cannot be restored to duty, he will be referred for discharge from the service under the provisions of AR 635-100 in the case of officers and warrant officers, including resignation for the good of the service; AR 635-212 for enlisted personnel.

(b) No individual will be discharged with a character of service under other than honorable conditions solely on the basis of his examination and identification as being a drug abuser or as having volunteered for treatment under the existing DOD drug identification and treatment programs.

(2) Reclassification/Withdrawal of MOS:

(a) Action to redesignate or withdraw any of the five characters of an awarded primary or secondary MOS may be initiated by any commander when he has determined sufficient cause exists.

(b) AR 600-200 outlines the necessary procedures. Identification as a drug dependent individual, per se, is not cause to initiate action for MOS reclassification or withdrawal as per AR 600-200. Only if the commander can specifically cite one of the disabling factors enumerated in Section VI may he initiate reclassification procedures. In any case, no reclassification action will be initiated until the completion of a reasonable (minimum 60 days) rehabilitation period, and the temporarily assigned S-2 profile is either rescinded or made permanent. If medical

authorities request that the commander initiate MOS reclassification proceedings for therapeutic reasons, he may initiate the action under the provisions of AR 600-200.

(c) Speciality and Superior Performance Pay. Since award of this pay is directly associated with a demonstrated proficiency related to a specific MOS, commanders do not have the authority to withdraw this unless they can show causes whereby the individual's demonstrated performance is below the standards required by the PMOS.

(3) Personnel Records. Any entries generated by action relating to the individual's participation in the CONARC Drug Abuse and Alcoholism Control Program will be in accordance with existing procedures as outlined in appropriate Army regulations. Within the purview of the current confidentiality afforded an individual identified through the CONARC Drug Abuse and Alcoholism Control Program, only those items absolutely required by existing regulations will be accomplished consistent with accepted personnel management procedures.

(4) Security Clearances:

(a) When it is determined that an individual is not drug dependent and is otherwise reliable, restoration of access following rehabilitation is considered appropriate.

(b) When the drug abuser proves to be drug dependent or otherwise unreliable and unable to respond adequately to rehabilitation efforts his security clearance should be revoked IAW AR 604-5.

(c) Commanders should take appropriate action on a case by case basis.

c. Special Services. Maximum use will be made of existing recreation and special services programs. In this regard, commanders will ensure that appropriate coordination between Special Services personnel and supervisors of drug abuse rehabilitation programs is accomplished. Supervisors will contact Special Services directors to obtain information on current activities, and Special Services directors will provide, on a recurring basis, schedules of activities to rehabilitation coordinators for the purpose of planning activities and scheduling facilities to assist in the rehabilitation program.

d. Project Transition/General Educational Development. Project Transition/General Educational Development (GED) services in support of the program will provide counseling, academic and vocational instruction and job placement services as a part of the rehabilitation process

of individuals. Educational services will be provided soldiers who have been deemed capable by medical authority to respond to positive action which will enable them, either through higher educational achievement or job skill training, to return to normal duties or civilian life as a responsible citizen. Transition services will be provided in accordance with CON Reg 621-4, Project Transition Directive and GED services in accordance with AR 621-5.

TAB A - Rehabilitation Facilities

TAB B - Drug Abuse Prevention and Control Teams

TAB A (Rehabilitation Facilities) to APPENDIX 3 (Rehabilitation Program)
to ANNEX D (Rehabilitation) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL
PROGRAM

1. PURPOSE. To outline procedures for the establishment and operation of drug rehabilitation facilities to support CONARC Drug Abuse and Alcoholism Control Program.

2. GENERAL. Halfway Houses - "Rap" Centers are facilities used in the rehabilitation of personnel with alcohol and drug problems. These facilities located in the larger military community provide the alcohol and drug dependent person and the user with a structured environment in which a variety of therapeutic models may be utilized.

3. OPERATING PRINCIPLES.

a. Referrals are accepted by these facilities but rehabilitation best occurs on a voluntary basis. Voluntary participation is a test of the individual's motivation at that time.

b. Information obtained by the staff should be treated "for official use only".

c. Recognizing the chronicity of the problem, rehabilitation efforts must continue for an adequate time (approximately sixty days) to evaluate progress.

d. The rehabilitation program for drug abusers should be in an informal setting. Personnel, however, must establish realistic limits for those individuals in the program and those who allow themselves to be manipulated by the alcohol abuser and drug user lose their effectiveness as a treatment resource.

4. FACILITIES.

a. Halfway House:

(1) A Halfway House is a live-in facility for alcohol and drug dependent personnel who perform duty in their assigned units during duty hours and return to this facility for supervised structured activities during off-duty hours. Activities are of a recreational, therapeutic, educational or training nature. The soldier is more closely supervised in his activities than in the usual company setting. Personnel assigned to operate this facility establish liaison with the individual's unit. They also provide the command with information regarding the general problem of alcohol and drug dependency and how to relate to alcohol abusers and drug users who are assigned to that particular unit.

(2) A Halfway House can be any self-contained facility, renovated to meet the following minimum requirements:

(a) A day room area which includes lounging chairs, television, and a variety of recreational games to include ping pong, pool and card tables.

(b) Rooms for small group counseling sessions, preferably sound proofed for privacy.

(c) Rooms adequate for individual counseling sessions.

(d) Billeting area and kitchen facility.

1. It is not recommended that there be separate rooms as individuals in the program should have exposure to peers.

2. The billeting area, however, should include fully panelled inclosures on four sides with a door on the hall side. This inclosure should allow four individuals to be billeted in same inclosure.

3. Kitchen area with stove and refrigerator.

(e) One administrative office.

b. "Rap" Center Program:

(1) The "Rap" Center is a centralized activity, usually located in the Halfway House, which provides various services to Army personnel and dependents not requiring residential Halfway House care. The command ADDIC provides operational supervision of the Center and coordinates its rehabilitative programs with other community agencies.

(2) The concept of operation of the Center must embody the preventive rehabilitation approach, emphasizing:

(a) Voluntary participation in the use of the facility and offering assistance to those with alcohol and drug related problems. Individuals can be referred to the facility but their participation will depend on individual motivation.

(b) A formal setting which functions on a 24-hour basis, seven days a week (but is fully staffed after duty hours) where soldiers and dependents may come to drink coffee, soft drinks, and "rap" with their peers.

(c) The Center staff provides coordination, consultation, liaison and referral service for soldiers and dependents as required.

(3) Organization:

(a) The installation commander must organize the "Rap" Center to meet the needs of his particular military community.

(b) The organizational structure of the Center will depend on local conditions and installation requirements.

(c) A volunteer program should be planned using reformed drug users and other individuals who are properly motivated and demonstrate their capabilities. These volunteers will add to the pool of manpower available to operate the facility.

(4) Functions:

(a) The primary function of the Center is to prevent alcohol and drug abuse through "rap" sessions and/or free discussion with peers. Rap sessions will develop whenever adequate numbers of individuals gather for this service. Sessions scheduled for presentations or panel discussions should be announced through command media. Discussions should be focused on the particular concern of the group at any time and leaders must not only have background in group discussion techniques but also be aware of happenings in the political, social, economic, and other areas and be able to redirect discussions to the alcohol and drug scene or culture.

(b) Other functions include:

1. Serving as a focal point in the coordination of rehabilitative efforts.

2. Acting as a liaison - referral service for military and other civilian community agencies.

3. Providing consultation to other agencies concerning its rehabilitation policies and practices.

4. Furnishing statistical and program reports pertaining to community related drug problems, projected activities, and community efforts, as required.

5. Developing policies and programs regarding "rap" sessions and discussions.

6. Individual and group psychotherapeutic sessions will be provided as personnel resources permit.

7. Provide liaison and consultation to the education programs on post related to alcohol and drug abuse prevention and control.

(5) Personnel:

(a) Prerequisites for the selection of personnel for "Rap" Centers are that they be interested, highly motivated individuals who have had experience in programs with alcohol and drug dependent persons. Personnel chosen should be of the younger age group to provide for peer identification, similar life experiences and life styles. The majority of drug users fall within the 14-30 age group. Alcohol abusers tend to be somewhat older.

(b) Officers with educational backgrounds in medical, social and behavioral sciences or experience with the military and civilian community health and welfare agencies should be selected for the supervision of "Rap" Centers.

(c) Enlisted counselors should be mature individuals with college education in the social and behavioral sciences, training as an educator, or practical experience with drugs. Ideally, the enlisted counselors would have had the educational background and/or practical experience in conducting individual or group counseling sessions. They must be of the personality type that can relate comfortably to youthful soldiers and dependents.

(d) Volunteers utilized from reformed alcoholics or drug users and others who desire to work in the Center must be carefully screened before acceptance.

5. SERVICES. The following services will be provided by the foregoing facilities, as appropriate.

a. Peer Group Sessions: Peer "rap" sessions may be of an informal nature or conducted through the use of formal techniques as guest speakers, panel discussions, psychodrama, or other innovations as determined by the group and the staff.

b. Individual Counseling (Psychotherapy): This consists of a one to one treatment process performed by professional personnel (i.e., psychiatrists, social workers) or by a trained, supervised specialist (i.e., social work/psychology specialists). Through the treatment process the drug user is helped to modify attitudes, beliefs, values, and change behavior in relation to the use of alcohol and drugs.

c. Individual Counseling (Vocational and Educational): This is a process performed by specialized counselors who can assist drug dependent personnel to deal with occupational uncertainty, develop employment objectives, and gain in vocational maturity. Counselors in the Army TRANSITION Program will be able to assist the drug dependent soldier with his vocational problems and provide educational and vocational training opportunities.

d. Group Counseling (Group Psychotherapy): A process guided by a professional and/or supervised specialist in which several individuals assemble informally to discuss their alcohol and drug related problems. Through the group interdynamics and treatment methods they change attitudes, values and behaviors, related to their problem. The group assists the individual to gain perspective into his self and into his relationships with others. The alcohol and drug user learns to substitute meaningful relations for his alcohol and/or drug use.

e. Recreational Sessions: Recreational activities conducted in the Halfway House for the purpose of providing new learning experiences, interactions and improved adjustments with others.

f. Information Services: Factual information regarding alcohol and drug use and abuse is provided either in person or by telephone. Individuals who have the need for alcohol and drug rehabilitative services are provided the name and location of agencies that can provide services in either the military or civilian communities.

g. Referral Service: In response to particular problems rehabilitation agencies must have resource lists to make quick and appropriate referrals. (Examples: Project TRANSITION, Health and Welfare Services, Education Services.)

h. Command Consultation: Contact with unit commanders regarding their alcohol and drug problem soldiers will be maintained and recommendations be made to commanders about actions which can be taken to influence changes in the soldiers inappropriate behavior.

i. Telephone "hot line": Accept crisis calls on 24-hour basis.

TAB B (Drug Abuse Prevention and Control Teams) to APPENDIX 3 (Rehabilitation Program) to ANNEX D (Rehabilitation) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To specify mission, scope and responsibility of the Drug Abuse Prevention and Control Team.

2. GENERAL. The Drug Abuse Prevention and Control Teams will perform the bulk of prevention, treatment, and rehabilitative work in drug abuse in the Halfway Houses at the local level. They are the operational arm of the installation/command ADDIC and report directly to it.

3. SCOPE AND RESPONSIBILITY:

a. General:

(1) HQ CONARC is providing additional manpower authorizations, military and civilian, and funding in support of Drug Abuse Prevention and Control Teams. Location, exact composition, and utilization of these teams is a function of command. Commanders should develop local plans and procedures, prepare facilities, and identify and recruit personnel for this function on an urgent basis.

(2) It is not intended that the use of non-professional or voluntary personnel, military or civilian, be inhibited in any way.

(3) The enlisted men are the most credible members of the teams, especially concerning drugs other than alcohol.

(4) In dealing with drug dependency the special training and attitudes of professionals are a disadvantage. They must prove their credibility before their expertise will be respected. Their main responsibilities will be administrative, supervisory, and consultative. They will be more directly useful with the older soldiers and officers, especially concerning alcoholism.

b. Specifics:

(1) Provide Preventive and Educational services, in coordination with unit Drug Education Specialists, by:

(a) Distributing information.

(b) Giving talks to small groups.

(c) Participating in discussion groups.

(d) Coordinating military with local civilian efforts.

(e) Encouraging active participation in the drug program by soldiers and volunteers in the dependent community (wives and children).

(f) Manning "hot lines".

(g) Being available on a 24-hour-a-day, 7-day-a-week basis to members of the military community who require assistance on an urgent basis.

(h) Providing a flexible program of activities through the Rap Center.

(i) Defining the scope and extent of drug use to identify populations at high risk of drug involvement.

(j) Concentrating preventive efforts on target populations, such as new recruits, Vietnam returnees, teenage dependents, middle-aged NCOs.

(2) Provide treatment and rehabilitation for men with drug problems by:

(a) Manning the Halfway House - Rap Center.

(b) Serving as a screening agency for physical complications of drug abuse.

(c) Acting as an identification and referral service to the hospital for acute drug toxicity such as heroin overdose or incipient delirium tremens.

(d) Treating all but severe overdosage effects of drug use in a non-hospital setting, e.g., "talking down" a bad trip or paranoid marijuana reaction.

(e) Supervising use of medications by persons in treatment.

(f) Leading group sessions and providing individual counseling, as indicated, for men with drug problems.

(g) Being available for intermittent ongoing supportive contact to men who can function in the military but who continue to show symptoms of drug taking.

4. ORGANIZATION:

a. Each Drug Abuse Prevention and Control Team should consist of:

(1) One each of the following: physician, social worker, chaplain, chaplain's assistant, and psychologist (half-time).

(2) Two psychiatric technicians.

(3) Five social work or psychology technicians.

(4) As available, one Project Transition counsellor from the installation Transition program.

b. Supportive personnel will be made available to assist the teams as local conditions dictate.

c. Branch clearance of the Chaplains assigned to the teams is required.

ANNEX E (Law Enforcement) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To prescribe policy and provide guidance concerning law enforcement activities related to drug and alcohol abuse.
2. GENERAL. Law enforcement activities should be conducted aggressively and in strict conformity with applicable laws and regulations. Special emphasis should be directed toward suppressing the supply of illegal drugs and detection and apprehension of personnel involved in trafficking. Close coordination and liaison with civilian law enforcement agencies is necessary to the overall suppressive effort.
3. OBJECTIVES.
 - a. To suppress the supply of illegal drugs available to Army personnel on CONARC installations.
 - b. To detect and apprehend individuals who illegally possess, use, sell or distribute drugs.
 - c. To participate with other agencies both military and civilian, in formulating and administering programs aimed at controlling drugs and preventing drug related crimes.
4. IMPLEMENTATION.
 - a. Provost Marshal Activities (Appendix 1).
 - b. Legal Aspects (Appendix 2).

APPENDICES:

- 1-Provost Marshal Activities
- 2-Legal Aspects

APPENDIX 1 (Provost Marshal Activities) to ANNEX E (Law Enforcement)
to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide guidelines for law enforcement activities related to drug and alcohol abuse.

2. IMPLEMENTATION.

a. Priority of law enforcement effort related to drug and alcohol abuse will be directed toward suppressing the illegal supply of drugs and the detection and apprehension of personnel involved in trafficking.

b. Expanded use of CID funds (limitation .015) is encouraged for the establishment of productive informant nets and the location of narcotic sources.

c. Establishment of narcotic sections in each CID office will be accomplished where feasible.

d. Undercover narcotic teams, under supervision of the CID, will be utilized where practicable in conjunction with representatives from state, county and city police agencies.

e. Provost Marshals, through the use of selective enforcement techniques, will increase vigilance in those areas where drugs might be introduced onto the installation.

f. Military Police and CID should monitor the AWOL apprehension program as a means of gaining intelligence on narcotic sources from AWOLs and deserters.

g. Provost Marshals or their representative, preferably the Deputy Provost Marshal, should be a member of the installation drug abuse council (ADDIC) and citizens advisory councils wherever possible.

h. Continuing liaison and coordination with federal, state, and local law enforcement agencies will be maintained at all levels to insure complete law enforcement coverage of illicit drug activities. Close coordination with the Staff Judge Advocate will be maintained to insure legal safeguards are in effect.

i. Wherever practicable, marijuana detector dogs will be utilized to the maximum extent possible to detect illicit drugs.

j. Announced and unannounced Physical Inspections and periodic Crime Prevention Surveys of facilities used in the storage and handling of drugs will be conducted by the Provost Marshals. Provost Marshals are to review and render technical advice on procedures for securing drugs with designated responsible individuals.

k. Thefts, losses, and unexplained disappearances of drugs will be investigated immediately to determine persons responsible and discrepancies in procedures or weaknesses in security. Violations of laws and regulations will be promptly reported to the commander concerned.

l. CID and trained Military Police personnel will be available as members of drug abuse lecturing teams for military installations and neighboring civilian communities.

m. Should the volume of drug investigations exceed the capabilities of the supporting criminal investigation element, major commanders may request authority through command channels to DA to use specially trained nonaccredited military policemen (MOSC 95B) to investigate cases involving possession of illicit drugs.

n. Training. Every effort will be made to train selected military policemen and all criminal investigators in drug investigations in special courses conducted by the US Army Military Police School and the Bureau of Narcotics and Dangerous Drugs.

APPENDIX 2 (Legal Aspects) to ANNEX E (Law Enforcement) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To identify legal aspects concerning law enforcement activities related to drug and alcohol abuse.

2. IMPLEMENTATION.

a. Drug exemption: See Appendix 1 to Annex A.

b. Search and Seizure:

(1) Conducting proper searches to seize evidence of illegal drug use is difficult and will end in failure without a general knowledge of the rules of search and seizure. An improperly conducted search may result in the inadmissibility of the seized items and often will deprive the government of all evidence of criminal conduct. A search to discover evidence to be used in a criminal prosecution must be based on probable cause.

(2) A commander can authorize a search only if he knows with a reasonable degree of probability that an offense has been committed, what items are to be searched for and where they are expected to be found. He can obtain knowledge of these facts based on the hearsay statements of others. Exceptions to this rule are:

(a) A commander or any individual may seize evidence of criminal conduct if the evidence is in open view or is located in a public use area, such as a dayroom.

(b) An individual may be searched incident to a lawful arrest or apprehension for the purpose of discovering weapons or preventing the destruction of evidence.

(c) Any individual may seize what clearly is evidence of criminal conduct in an emergency situation when immediate action is necessary to prevent removal or disposal of the evidence.

(d) It is recommended that close liaison be maintained with the local Staff Judge Advocate for more detailed guidance in this area.

c. Inspections. Search and seizure restrictions do not limit the commander's inherent authority to conduct inspections (including so-called "shake-down" inspections). An inspection does not presuppose a criminal offense; it is wholly administrative and preventive in nature. Inspections may be used as a safety measure for the purpose of discovering and removing contraband weapons, as well as for the purpose of determining the fitness and readiness of units to perform their mission. Such items as unauthorized weapons or drugs discovered during either type of inspection may be used as evidence at a court-martial. However, a general barracks inspection may not be used as a

subterfuge to effect the search of the living area of a person accused or suspected of having contraband or other evidence of crime in his possession.

d. Disposition of Persons Involved in Drug Use:

(1) The immediate commander will evaluate each person involved in an incident of drug abuse and will determine the appropriate administrative disposition of his case.

(2) Soldiers convicted by court-martial of offenses involving controlled substances, will be considered for rehabilitation. In determining whether such treatment is appropriate, consideration should be given to all of the circumstances involved.

(3) When confinement is adjudged, the prisoner will receive a medical and psychiatric evaluation before a determination is made concerning the place of confinement and/or treatment. Prisoners not medically cleared will be sent to a medical facility for treatment. A place of confinement for prisoners medically cleared will be designated under the provisions of AR 190-4, giving weight to the availability of facilities for rehabilitation at the confinement installation designated.

(4) Persons who are convicted by civil courts for alcohol or drug abuse and persons who are unfit for further military service because of alcohol or drug abuse will be considered for administrative separation under the provisions of AR 635-100, AR 635-120, AR 635-200, AR 635-206, AR 635-212, AR 135-175, or AR 135-178. If administrative separation is not appropriate, these individuals will be afforded rehabilitative treatment as described in Annex G.

e. Prohibitions and Penalties:

(1) Army personnel will not use, possess, sell, distribute, deliver, process, compound, or manufacture any controlled substance, nor will they introduce any such drug onto an Army installation or other government property except that which has been legally obtained for a purpose or use authorized or accepted by law.

(2) Any paraphernalia used to wrongfully inject, inhale or administer controlled substances to the body is prohibited.

(3) Violators of above prohibitions may be prosecuted under Articles 92 and 134, UCMJ, or other appropriate articles of the Code, or administrative action may be taken in accordance with applicable directives.

ANNEX F (Resource Requirements) to CONARC DRUG ABUSE AND ALCOHOLISM
CONTROL PROGRAM

1. PURPOSE.

a. To provide information and guidance pertaining to funding for support of this program.

b. To provide policy and guidance with respect to installation facilities required for the conduct of this program.

c. To provide guidance for the establishment of manpower requirements and preparation of TDA's.

d. To provide information and guidance concerning procurement and retention of personnel required for the overall conduct of this program.

2. GENERAL. It is fully recognized that a program of this magnitude and importance cannot meet with the required measure of success unless the necessary resources are provided. However, as a practical matter subordinate commanders must plan for the utilization of their existing resources until men, money, and materials can be provided through budgetary procedures. The pressing and critical nature of the Army's drug problem does not allow for the luxury of delay. Moreover, commanders at all levels must insure the involvement in sufficient numbers of their best and most qualified personnel even if other programs must be reduced. Fully manned and highly effective organizations must exist to manage and operate the drug programs.

3. IMPLEMENTATION.

a. Funding (Appendix 1).

b. Installation and Facilities (Appendix 2).

c. Manpower (Appendix 3).

d. Personnel (Appendix 4).

APPENDICES:

1-Funding

2-Installation and Facilities

3-Manpower

4-Personnel

APPENDIX 1 (Funding) to ANNEX F (Resource Requirements) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To prescribe general guidance concerning availability and expenditure of funds for CONARC Drug Abuse and Alcoholism Control Program.

2. GENERAL. DA has allocated to CONARC \$4.5 million in Program 8 Medical for the conduct of its FY 72 Drug Abuse and Alcoholism Control Program. Funds have been distributed to the CONUSA based on a prorated figure of \$68,182.00 per Halfway House facility required. \$1.5 million was retained by HQ CONARC for subsequent distribution pending DA decision as to additional funds for other programs. It is envisaged that the preponderance of Program 8 Medical Funds now available will be used for procurement of civilian personnel required for staffing of the Halfway House facilities.

3. RESPONSIBILITY: The CONARC Surgeon is responsible for maintaining cost data for CONARC Drug Abuse and Alcoholism Control Program, and, based on these data, requesting those funds required to support the program.

4. IMPLEMENTATION:

a. Allocation of funds.

(1) Distribution of initial Program 8 Medical Funds has been made as follows:

- (a) USAONE - \$818,184.00
- (b) USATHREE - \$954,548.00
- (c) USAFIVE - \$818,184.00
- (d) USASIX - \$409,092.00

(2) The above funds have been assigned to Key Account Code 841216.8 pending revised Key Account Code assignment.

(3) Additional FY 72 funds will be allocated to commands based on costs incurred for this program. Programs will be adjusted accordingly at the FY 72 Budget Execution Review (Mid-Year Review).

(4) Funds for FY 73 should be requested through appropriate channels. Because of one-time purchases for supplies and equipment in FY 72, it is anticipated that FY 73 requirements will be less than FY 72.

b. Additional Implementing Instructions:

(1) Where specific guidance or instructions have not been issued to assess and/or report the financial impact of this program on command requirements, existing budgetary procedures will be followed.

(2) Funds to support the program will be made available to commands through the normal funding process.

(3) Expenses associated with this program will be accumulated and reported in accordance with instructions contained in Headquarters, CONARC letter, ATMED, 1 September 1971, subject: Cost of Drug Abuse Program, RCS MED - 278.

APPENDIX 2 (Installations and Facilities) to ANNEX F (Resource Requirements) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide policy and guidance with respect to installations and facilities required for the conduct of this program.

2. GENERAL.

a. Initially, the provision of drug treatment facilities will be primarily limited to "Halfway Houses" and "Rap" Centers for rehabilitation purposes. It is envisioned that medical treatment for the purposes of prevention, identification or detoxification will be primarily provided in presently constructed facilities.

b. Funding for these facilities, i.e., MCA, OMA, or Minor Construction cannot be determined at this time but will be influenced by both the scope and urgency of the requirement when compared to the existing facilities. It is envisioned that these facilities will initially be austere. The decor and furnishings should contribute to the overall therapeutic purpose of the facility.

3. IMPLEMENTATION.

a. Pending further guidance, for planning purposes, two types of facilities are envisioned: A Halfway House and a "Rap" Center.

(1) Halfway house is a live-in facility to house 20 drug dependent residents. It is a self contained renovated structure that requires:

(a) Five rooms to adequately accommodate four beds per room and the personal effects of the occupants.

(b) Two group counseling session rooms for six persons and one room for fourteen persons.

(c) A day room recreation area.

(d) A snack service area to house a refrigerator, hot plate and minimal storage.

(e) An administrative office.

(f) Two individual counseling rooms.

(g) A latrine to accommodate twenty live-in residents.

(2) "Rap" Center - a preventive rehabilitation facility that is renovated to include:

(a) A large room to accommodate 30 or 50 persons depending on post size and need.

(b) Recommend partitions divide large room into smaller areas.

(c) An administrative office.

(d) Four individual counseling rooms.

(e) Men's and women's rest rooms.

(f) A storage room.

b. Typical furniture and recreational materials for drug service facilities.

(1) Halfway House:

(a) Three desks and chairs.

(b) Twenty beds and wall lockers.

(c) Thirty chairs.

(d) One refrigerator.

(e) One hot plate and coffee pot.

(f) Six lounge chairs.

(g) Two 3-cushion couches.

(h) One TV.

(i) One radio-phonograph combination.

(j) One pool table.

(k) One ping pong table.

(1) Intercom.

(2) "Rap" Facility:

(a) Five desks and chairs.

(b) Fifty stack or folding chairs.

- (c) One refrigerator.
- (d) One hot plate and coffee pot.
- (e) Two fold away long tables.
- (f) Music system-intercom combination.

c. Initially, maximum use will be made of existing structures and facilities to keep construction requirements to a minimum.

d. For planning purposes the number of halfway house - rap centers have been programed at the following locations:

(1) USAONE	12
(a) Aberdeen Proving Ground	2
(b) Fort Belvoir	1
(c) Fort Devens	1
(d) Fort Dix	2
(e) Fort Eustis	1
(f) Fort Knox	2
(g) Fort Lee	1
(h) Fort Meade	1
(i) Fort Monmouth	1
(2) USATHREE	14
(a) Fort Benning	2
(b) Fort Bragg	2
(c) Fort Campbell	2
(d) Fort Gordon	2
(e) Fort Jackson	2
(f) Fort McClellan	1
(g) Redstone Arsenal	1

(h) Fort Rucker	1
(i) Fort Stewart	1
(3) USAFIVE	12
(a) Fort Hood	2
(b) Fort Leonard Wood	2
(c) Fort Polk	2
(d) Fort Riley	2
(e) Fort Sill	2
(f) Fort Wolters	1
(g) Fort Leavenworth	1
(4) USASIX	6
(a) Fort Huachuca	1
(b) Fort Carson	2
(c) Fort MacArthur	1
(d) Fort Ord	2

APPENDIX 3 (Manpower) to ANNEX F (Resource Requirements) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide manpower guidance to assist commanders in the implementation and conduct of CONARC's Drug Abuse and Alcoholism Control Program.
2. GENERAL. DA has allocated HQ CONARC 171 military and 1,592 civilian spaces for support of manpower requirements of the CONARC Drug Abuse and Alcoholism Control Program. The spaces will be allocated on 2d Quarter Manpower Vouchers. Allocation of these spaces will be forwarded to CONUSA under separate cover.
3. IMPLEMENTATION.
 - a. A review of stated manpower requirements for Drug Abuse and Alcoholism Control indicates that requirements listed by Armies may have been previously validated by this headquarters. Commanders will establish controls to insure that there are no duplications of requirements or requests for manpower spaces.
 - b. Instructions for the hiring of civilian personnel and instructions regarding the availability of manpower spaces to satisfy HQ CONARC validated requirements are provided by CONARC messages (091221 Aug 71, 1st Army); (091222 Aug 71, 3d Army); (091223 Aug 71, 5th Army); (091224 Aug 71, 6th Army), subject: Civilian Employment Levels, FY 72.
 - c. Standard manpower procedures will apply to the Drug Abuse and Alcoholism Program. The following apply:
 - (1) Manpower requirements previously validated by HQ CONARC in support of installation workloads existing prior to 1 September 1971, and which are now identified primarily with drug abuse do not require rejustification but must be identified in TAADS documents by nonstandard remark OOAG.
 - (2) Additional manpower requirements must be fully justified in accordance with provisions of CON Reg 1-45, however, the provisions of paragraph 9e are suspended for Drug Abuse and Alcoholism submission.
 - (3) Military manpower requirements will be delineated by identity (i.e., Off, ANC/AMSC, WO, ENL) and in case of AMEDD officer spaces, as MC, VC, DC or MSC.
 - (4) Manpower requirements/allocations in support of Drug Abuse and Alcoholism Program, subsequent to approval by HQ CONARC, will be reflected in appropriate TDA. CONARC standard remark OOAG and AMS Code 841211.1300 will be used to identify those entries. Changes to TDA will be processed in accordance with AR 310-49, as supplemented by letter, this headquarters, dated 30 April 1971, subject: TAADS Procedures.

d. Manpower requirements submitted on Schedules X must be appropriately identified with specific projects.

e. Military spaces provided should be by trade off, however, DA will consider high priority requirements. Installations are urged to identify manpower requirements as "civilian" where possible.

f. Workload data will be maintained on all Drug Abuse and Alcoholism utilized manpower, since personnel so employed will be subject to future manpower survey action.

g. If installations contemplate use of personnel in support of duties and functions not currently authorized by AR or Public Law, those duties/functions will be identified together with the appropriate AR or Public Law, to assist this headquarters in processing a request for waiver prior to assignment of personnel to such duties.

APPENDIX 4 (Personnel) to ANNEX F (Resource Requirements) to CONARC
DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide information and guidance concerning procurement and retention of personnel required for the overall conduct of this program.

2. IMPLEMENTATION.

a. Requisitioning:

(1) Enlisted: Requisitions for enlisted personnel will be submitted through channels to this headquarters, ATTN: ATPER-MPO-EA, in accordance with Chapter 2, AR 614-200 and CONARC Supplement 1 thereto when fill cannot be accomplished from local resources. An exception to paragraph 2-2a, AR 614-200, enlisted personnel required to staff these facilities will be requisitioned against recognized positions pending approval of authorization documents. Requisitions will be "Z - coded" to indicate special prerequisites for the assignments.

(2) Officers: Officer requisitions will be filled from local resources until they can be filled through normal requisitioning procedures. Officer personnel required to staff drug abuse and alcohol control facilities are to be requisitioned against recognized positions upon approval of authorization documents in accordance with AR 614-185 and CONARC Supplement thereto. Advance requirements may be forwarded for consideration prior to approval of spaces. However, no fill action can be expected until spaces are authorized.

b. Stabilization: Drug abuse and alcohol control programs throughout CONARC require retention of qualified personnel for the continued effective accomplishment of these programs. Commanders of activities administering these programs may submit, with individual justification, request for stabilization of essential personnel UP paragraph 1-4j, AR 614-5. Commanders should initiate action for stabilization of key personnel immediately upon determination for such action.

ANNEX G (Information Program) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE.

a. To provide policy guidance and procedures for information activities associated with actions being taken by Department of the Army to identify, counsel and rehabilitate drug and alcohol users.

b. To provide support to CONUSA in carrying out their information mission in the execution of this plan.

2. GENERAL. Due to the high degree of public interest in the area of drug abuse in the Army as well as the society in general, the CONARC Information Program must be conducted in a candid and factual manner. Moreover, an extensive and credible information program, which emphasizes the dangers of drug abuse, must be conducted at all command levels. Further, it can be expected that commanders will receive continuing inquiries from local and national news media concerning the magnitude of the drug abuse problem and their respective efforts at prevention, control and rehabilitation.

3. OBJECTIVE.

a. To provide the public with maximum information, within DOD restrictions, about the Army's role, mission and activities in connection with the execution of this plan, consistent with national security.

b. To insure that military personnel are fully informed of all aspects of this program.

c. To insure that the individual undergoing treatment does not have his right to privacy violated.

d. To provide maximum assistance to commanders in the development and conduct of education and training programs.

4. IMPLEMENTATION.

a. General:

(1) Guidelines for release of information:

(a) Unclassified information based on facts and verifiable data will be provided the news media in response to queries except as noted in paragraphs (d) and (e) below.

(b) Interviews or photographs of individuals being tested or undergoing detoxification or treatment are not authorized without the consent of the individual and then only after competent medical and rehabilitation authorities, directly involved with their treatment, have granted permission for the interview.

(c) Tours of facilities and discussions with medical personnel must have the approval of the facility commander.

(d) Information on quantitative results derived from testing personnel for drug abuse will be disclosed only if previously released by DA or higher authority.

(e) Photographs and interviews of persons identifiable as participants in the drug program are not authorized while in transit.

(f) Patients or individuals convicted of drug related crimes may be interviewed if the individual consents and he is not in confinement. Those in accused status may not be interviewed as it may prejudice judicial process.

(g) Statistics pertaining to the Drug Program at individual installations, except for data related to urinalysis screening, may be released locally. Examples of data that may be released are: Number of applicants for local immunity program; cost of running a local "halfway house". No application of local statistics will be made to the overall program existing within the Army. No comment will be made regarding Vietnam returnees in the Drug Treatment Program.

b. Responsibilities:

(1) HQ CONARC:

(a) Coordinate all information activities in support of this plan.

(b) Disseminate guidance and fact sheets on Drug and Alcohol Abuse and provide technical assistance regarding this program.

(c) Procure and disseminate information materials in support of the Drug Education Specialist Program (see Appendix 1 to Annex C).

(d) Respond to queries as outlined in paragraph 4a(1).

(2) Major Subordinate Commands:

(a) Insure guidance and fact sheets are given widest distribution.

(b) Respond to press queries concerning the program.

(c) Disseminate information using command information materials and channels.

5. ADMINISTRATION.

a. Direct coordination between interested information officers is authorized.

b. Authority for release of additional information must be directed through CONARC IO (autovon 680-3358) to OCINFO, DA, PID (OX 7-2351) Appendix 1 Command Information.

APPENDIX:

1-Command Information

APPENDIX 1 (Command Information) to ANNEX G (Information Program) to
CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To provide policy and guidance for Command Information Programs pertaining to Drug and Alcohol Abuse.

2. GENERAL. The complexity of the Drug and Alcohol Abuse problems within the Army necessitate implementation of a comprehensive and credible Command Information Program designed to assist education and training programs developed by commanders. Such a program must also encourage commanders to deal objectively with Drug and Alcohol problems within their units and must insure that the privacy and dignity of individuals involved in the rehabilitation process is protected.

3. IMPLEMENTATION.

a. Responsibilities:

(1) IO, CONARC will:

(a) Publish fact sheets, CI news releases for CONARC Newspapers, Commanders Call Topics and other materials pertinent to the problem.

(b) Coordinate the production of CI materials, video tapes, and other media materials produced by CONUSA IO's.

(c) Reprint, as part of its information materials, Interchange Program, outstanding instructional publications and materials produced throughout CONARC.

(d) Coordinate CONUS Army-wide programs in accordance with policy and subject guidance of DOD and DA.

(e) Maintain close liaison with OCINFO, DA on content of CI materials to assure compliance with pertinent policy and regulations.

(2) Major Subordinate Commands:

(a) Publish appropriate CI Materials to meet requirements of local education and training programs.

(b) Maintain liaison with CONARC IO to insure adherence to policy guidelines of DOD and DA.

4. ADMINISTRATION. Direct coordination between CONUS IO's is authorized.

ANNEX H (Reports) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To establish procedures for the collection and evaluation of alcohol and drug abuse statistics concerning the prevention, identification, detoxification, treatment and rehabilitation of individuals in support of HQ CONARC Drug Abuse and Alcoholism Control Program.

2. GENERAL. Data obtained from reports presented herein will be used to maintain and evaluate progress in the CONARC Drug Abuse and Alcoholism Control Program. It can be expected that changes in reporting requirements will occur as the data base is refined. Some reports will subsequently be rescinded and others changed to meet new requirements as they develop.

3. RESPONSIBILITIES.

a. DCSPER, CONARC will:

(1) Maintain overall responsibility for collection, evaluation and dissemination of data obtained in support of the CONARC Drug Abuse and Alcoholism Control Program.

(2) Maintain specific staff responsibility for development and evaluation of education and other prevention programs in support of the CONARC Drug Abuse and Alcoholism Control Program.

b. Surgeon, CONARC, will collect, evaluate, and report to DCSPER data concerning identification, detoxification, treatment, and rehabilitation of alcohol and drug dependent individuals, as required.

c. Provost Marshal, CONARC, will collect, evaluate, and report to DCSPER data pertaining to alcohol and drug abuse offenses, as required.

d. CONUSA will collect, evaluate, and report to HQ CONARC data pertaining to identification, detoxification, treatment, rehabilitation, prevention and education, as required.

4. DATA TO BE COLLECTED AND REPORTING PROCEDURES.

a. The data prescribed herein are not all inclusive. Changes and modification of existing reports as well as special "One Time" reports will be required from time to time to meet special requests from higher headquarters.

b. DCSPOR (ATFOR):

(1) RCS CSFOR-78 (Part A). A supplement to the monthly report will be submitted to reflect the data required for civilian personnel by the

appropriate code. Military personnel will be reflected in the supplement to the quarterly submissions. Initial manpower reports will be for the period ending 30 Nov 71.

(2) RCS CSFOR-78 (Part B). A supplement to the semi-annual report will be submitted to explain the impact of Drug Abuse to each UIC and AMS Code within each code affected. Initial reports will be for the period ending 30 Nov 71.

(3) RCS CSFOR 128. Drug Abuse spaces will be reflected following each UIC as a non-add entry in each quarterly report.

(4) RCS CSGPA 969 (Civilian Personnel Employment Record, DA Form 3250) will reflect the total number employed on the roles at the end of the month as an entry in Item 47, Remarks, for civilian personnel occupying Drug Abuse and Alcoholism spaces.

c. DCSPER (ATPER): RCS ATPER-286 (MIN).

d. Provost Marshal (ATPM): RCS PMG-2(R8) DA Form 2819.

e. Surgeon (ATMED);

(1) RCS SAOSA-136 (DA Form 3711-R).

(2) RCS DD-M(SM) 1094 (MIN).

(3) RCS MED 277 (MIN).

(4) Hospitalization and Disposition Reports, IAW AR 40-400, as changed.

ANNEX I (References) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. To list references applicable to CONARC Drug Abuse and Alcoholism Control Program.

2. DIRECTIVES.

a. Army Regulations:

(1) Drug Abuse: AR 600-32, Drug Abuse Prevention and Control, with Change 1.

(2) Medical:

(a) AR 40-8, Temporary Restrictions of Flying Duties Due to Extraneous Physiological Reasons.

(b) AR 40-20, Evacuation of Patients.

(c) AR 40-350, Medical Regulating to and within CONUS.

(d) AR 40-400, Individual Patient Data System.

(e) AR 40-403, Health Records.

(f) AR 40-425, Outpatient Medical and Dental Records.

(g) AR 40-501, Standards of Medical Fitness.

(h) AR 40-530-7, Patient's Identity Tag, Patient's Baggage Tag, Patient Evacuation Manifest, and Patient's Unaccompanied Baggage.

(i) AR 40-535, World-wide Aeromedical Evacuation.

(3) Personnel:

(a) AR 135-175, Reserve Components - Separation of Officers.

(b) AR 135-178, Reserve Components - Separation of Enlisted Personnel.

(c) AR 600-10, The Army Casualty System.

(d) AR 600-200, Enlisted Personnel Management.

(e) AR 601-270, Armed Forces Examining and Entrance Stations.

(f) AR 611-15, Selection, Assignment and Retention Criteria for Personnel in Nuclear Reactor Positions, Nuclear Weapons Position, and Command and Control Positions.

(g) AR 614-30, Overseas Service.

(h) AR 614-200, Enlistment Personnel Selection, Training and Assignment System, Grades E-1 through E-9.

(i) AR 635-100, Officer Personnel.

(j) AR 635-120, Officer Resignations and Discharges.

(k) AR 635-200, Enlisted Personnel.

(l) AR 635-206, Misconduct.

(m) AR 635-212, Discharge - Unfitness and Unsuitability.

(n) AR 640-10, Military Personnel Records Jacket US Army.

(4) Law Enforcement:

(a) AR 15-3, Armed Forces Disciplinary Control Boards.

(b) AR 55-73, Customs and Other Entry Requirements and Related Services.

(c) AR 65-1, Army Postal Operating Instructions.

(d) AR 190-4, Uniform Treatment of Military Prisoners.

(e) AR 190-19, Military Police Correctional Training Facilities.

(f) AR 190-22, Search, Seizure and Disposition of Property.

(g) AR 190-46, Provost Marshal Activities (RCS PMG-2 (R8)).

(h) AR 195-4, Use of CIO Funds for CI Activities.

(i) AR 195-10, Military Police Criminal Investigative Activities.

(j) AR 196-33, Physical Security Inspections.

(5) Security: AR 604-5, Personnel Security Clearance.

(6) Research:

(a) AR 5-5, Army Study System.

(b) AR 705-5, Army Research and Development.

b. DA Letters:

(1) AGDA (M) MEDPS-CN, dated 7 December 1970, subject: Alcohol and Drug Dependency Intervention Councils (ADDIC).

(2) AGDS-A (M), dated 6 April 1971, subject: Drug Abuse Data: RCS SAOSA-136.

(3) AGDA-A (M), dated 10 August 1971, subject: Directory of Civilian Drug Treatment Programs.

c. DA and CONARC Messages:

(1) General:

(a) DA 132229Z Apr 71, subject: Drug Abuse Prevention and Control.

(b) DA 192124Z Jun 71, subject: Drug Abuse Counter Offensive.

(c) DA 101500Z Jul 71, subject: Drug Abuse Counter Offensive.

(d) DA 122228Z Jul 71, subject: Policy on Punishment and Discharges of Drug Abuses.

(e) DA 101900Z Aug 71, subject: Interim Public Affairs Guidance Pertaining to Drug Abuse Prevention and Control.

(f) CONARC 161714Z Jul 71, subject: Drug Abuse Prevention and Control Program.

(2) Personnel:

(a) DA 132229Z Apr 71, subject: Moratorium on Enlisted Personnel Reclassification Actions.

(b) DA 152123Z Apr 71, subject: Processing Personnel for Separation - Drug Abuse.

(c) DA 081205Z May 71, subject: Line of Duty Findings in Drug Amnesty Cases.

(d) DA 271637Z Jun 71, subject: Guidelines to CONUS Commanders Concerning Treatment of Active Duty Army Drug Dependent Personnel Returning from Vietnam by Aeromedical Evacuation.

(e) DA 282235Z Jun 71, subject: Moratorium on MOS Reclassifications.

(f) DA 061830Z Jul 71, subject: Guidelines for Commanders Regarding Assignment of Soldiers After Inpatient Drug Treatment.

(g) DA 121250Z Jul 71, subject: Processing Procedures of CONUS Ports of Entry for Personnel Released from Drug Quarantine Facilities.

(h) DA 141231Z Jul 71, subject: LD Procedures for Drug Identification and Treatment Program of the US Army.

(i) DA 201655Z Jul 71, subject: Lab Testing for Drug Abuse Counter Offensive.

(j) DA 282036Z Jul 71, subject: Reassignment of Soldiers After Inpatient Drug Treatment.

(k) DA 091843Z Aug 71, subject: Assignment Instructions for Drug Abuse Prevention and Control Plan.

(l) DA 092045Z Aug 71, subject: Continuity of Treatment of Drug Abusers.

(m) DA 101201Z Aug 71, subject: Processing Procedures for Individuals Returning from Overseas Areas Identified as Drug Users (Non-Dependent).

(n) DA 131335Z Aug 71, subject: Clarify Clearance Procedures Involving Drug Abusers.

(o) DA 202147Z Aug 71, subject: Guidelines to Commanders Concerning Treatment of Active Duty Army Identified Drug Users Returning from Overseas Areas by Aeromedical Evacuation.

(p) DA 301405Z Aug 71 (See above).

(q) DA 301906Z Aug 71, subject: Urinalysis Screening of Personnel Entering Army.

(r) DA 011805Z Sep 71, subject: Federal Civilian Employee Alcoholism Programs.

(s) DA 081802Z Sep 71, subject: Personnel Accounting for Identified Drug Abuse Personnel Returning from Overseas.

(t) CONARC 251516Z Jun 71, subject: Drug Abuse Counter Offensive (VA Hospitals).

(u) CONARC 151415Z Jul 71, subject: Guidance to Commanders Pertaining to Rapid Development and Implementation of CONARC Drug Abuse Prevention and Control Plan.

(v) CONARC 161921Z Jul 71, subject: Personnel Stabilization.

(w) CONARC 252030Z Jul 71, subject: Instructions Concerning Assignment/or Other Disposition of Personnel Returning to CONUS.

(x) CONARC 282120Z Jul 71, subject: Instructions Concerning Assignment or Other Disposition of Pers Returning to CONUS Drug Abuse Program.

(y) CONARC 082125Z Sep 71, subject: Lab Testing for Drug Abuse Counter Offensive.

(3) Training:

(a) CONARC 292147Z Jul 71, subject: Drug Abuse Training in USATC'S, NCO Academies and Drill Sergeant Schools.

(b) CONARC 062035Z Aug 71, subject: Drug Abuse Training Proponency.

(4) Resources:

(a) DA 261315Z Aug 71, subject: MPR Spaces for the Dept Army Alcohol and Drug Abuse Prevention and Control Program.

(b) DA 271330Z Aug 71, subject: Drug Treatment Facilities.

(c) CONARC 302131Z Jul 71, subject: Civilian Recruitment Planning for Army Drug Abuse Prevention Control Program.

(5) Reporting Requirements:

(a) DA 182023Z Jun 71, subject: Drug Abuse Data.

(b) DA 032038Z Aug 71, subject: Drug Abuse Counter Offensive: Reporting Procedures of Personnel Released from Active Duty.

(c) DA 301200Z Aug 71, subject: Status Rept of Drug Related Admissions from Overseas Areas.

(d) DA 301201Z Aug 71, subject: Medical Reporting Requirements for Test and Identification of Drug Abuse Prevention and Control Programs.

(e) CONARC 171907Z Aug 71, subject: Drug Abuse Counter Offensive Reports.

d. Educational Materials (Drug Abuse):

(1) DA Pamphlets:

- (a) 360-530 Drug Abuse: Game without Wimmers (under revision)
Answers to the most frequently asked questions
about drug abuse (Federal Source Book).
- (b) 360-602 Drugs and You
- (2) DA Posters:
 - (a) 360-122 Keep off the Grass
 - (b) 360-123 Speed Gets You Nowhere
 - (c) 360-124 Don't be Needled by Drugs
 - (d) 360-125 One Mind Is All You Get -- Don't Blow It
 - (e) 360-129 Drug Abuse: Escape to Nowhere
 - (f) 360-130 Dead End
 - (g) 360-131 Warning: Speed Trap
 - (h) 360-132 Why Do You Think They Call It Dope?
- (3) Motion Pictures:
 - (a) AFIF-196 Marijuana
 - (b) TAR 30 CRASH
- (4) DAD Command Information Fact Sheets:
 - (a) 169 Nine-Year Nightmare
 - (b) 183 Drug Tests For Vietnam Returnees
- (5) American Red Cross: "Drugs and Their Use" Available at 4¢
per copy from: General Supply Office, American National Red Cross HQ,
17th and D Streets, Washington, D. C.
- (6) Bureau of Narcotics and Dangerous Drugs: "The Drugs of Abuse"
- (7) National Institutes of Mental Health: Some Questions and
Answer series:
 - LSD
 - Marijuana
 - Narcotics

Stimulants

Sedatives

e. Department of the Army Alcohol and Drug Abuse Prevention and Control Plan.

ANNEX J (Bibliography) to CONARC DRUG ABUSE AND ALCOHOLISM CONTROL PROGRAM

1. PURPOSE. This bibliography is presented only as a list of suggested resources and is by no means complete. Additions to this list will follow.

2. ALCOHOL ABUSE.

a. Alcoholism, Diagnosis, and Treatment (Reprint from Patient Care: June-Nov 1969), available through writing and requesting from Ayerst Laboratory, New York, N.Y. 10017

b. R. J. Catanzaro, "One Man Team Approach for the Treatment of Alcoholics", Military Medicine, Vol 129 (July 1964) pp. 664-67.

c. "The Medical General Hospital" Alcoholism A Total Treatment Approach ed. R. J. Catanzato, Springfield, Ill. Charles Thomas Co, 1969, pp. 387-92.

d. A. J. Glass, Drug Addiction and Alcoholism - psychiatric Considerations Based on Professional Medical Experiences in Japan and Korea, 1950-53. Washington, D. C.: US Government Printing Office. 1954, Vol 2, pp. 159-69.

e. M. Ginsburg, "The Treatment of the Problem Drinker in the Overseas Theatre by the General Medical Officer" Military Medicine, Vol. 127 (1962), pp. 416-22.

f. L. Hill, "Bliss Conducts Alcoholic Treatment Program" Air Defense Monitor, Vol. XXVI, 6 Mar 1969.

g. L. Lasanga, "The Many Faces of Drug Abuse", Modern Medicine Vol. 38 (1970) pp. 144-76.

h. E. Plant, A Report to the Nation, National Council on Alcoholism, London & New York: Oxford University Press, 1967.

i. R. C. Scibetta and L. W. Dunlap "Alcoholism: Observations at USAF Medical Center Wright - Patterson", Digest (Feb 1971) Vol XXII, No 11, pp. 1-12.

j. R. J. Shearer. ed, Manual on Alcoholism, The American Medical Association, 1968 (may be obtained by requesting from AMA).

k. Solomon and Yakovlev, The Manual of Military Neuropsychiatry, New York: W. B. Saunders Co., 1944. Chapter on Alcoholism and Alcoholic Abuse, pp. 180-84.

1. L. J. West and W. H. Swegan, "An Approach to Alcoholism in the Military Service", American Journal of Psychiatry, Vol. 112 (1956), pp. 1004-1009.

m. The Key Step. A Model Program to Deal with Drinking Problems of Employees. United States Civil Service Commission, US Government Printing Office, Jan 1969 (25 cents).

n. The First Step: A Report of a Conference on Drinking Problems Nov 7-8, 1967. United States Civil Service Commission, US Government Printing Office, April 1968 (20 cents).

o. Drug and Alcohol Abuse in the Military, Hearing Before the Special Subcommittee on Alcohol and Narcotics of the Committee on Labor, US Government Printing Office, 1971.

p. Narcotics and Alcoholism, Hearing Before the Subcommittee on Alcoholism & Narcotics of the Committee on Labor & Public Welfare United States Senate, 92nd Congress, United States Government Printing Office, 1971.

3. DRUG ABUSE.

<u>TITLE</u>	<u>AUTHOR</u>	<u>PUBLISHER</u>
a. DRUG AWARENESS	Horman, R.	Avon
b. THE DRUG SCENE	Louria, D.	Bantam
c. THE SEEKERS	Stearn	Bantam
d. ALL ABOUT DRUGS	Bergel, F.	Barnes & Noble
e. NARCOTICS: NATURE'S DANGEROUS GIFTS	Taylor, N.	Dell
f. DRUGS ON THE COLLEGE CAMPUS	Nowlis, H.	Doubleday
g. NARCOTICS - AN AMERICAN PLAN	Jeffee, S.	Erikson
h. ADDICT	Wakefield, D.	Fawcett
i. THE ADDICT IN THE STREET	Larner, J.	Grove
j. DRUGS & ALCOHOL	Jones, K.	Harper
k. NARCOTIC ADDICTION	O'Donnel, J.	Harper

<u>TITLE</u>	<u>AUTHOR</u>	<u>PUBLISHER</u>
1. FOR AND AGAINST	Hart, H.	Hart
m. DRUGS & YOUTH	Coles, R.	Liveright
n. THE DRUG DILEMMA	Cohen, S.	McGraw
o. DRUG BEAT	Gellor, A.	McGraw
p. DRUGS FROM A TO Z: A DICTIONARY	Lingeman, R.	McGraw
q. MARIHUANA PAPERS	Solomon, E.	NAL
r. DRUGS: MEDICAL, PSYCH- OLOGICAL AND SOCIAL FACTS, REV. ED	Lauries, P.	Penguin
s. TUNNEL BACK	Yablonsky, L.	Penguin
t. DRUGS FOR YOUNG PEOPLE: THEIR USE AND MISUSE	Leech, K.	Pergamon
u. MIND DRUGS	Hyde, M.	Pocket Books
v. WHAT YOU SHOULD KNOW ABOUT PILLS	Liston, R.	Pocket Books
w. DRUGS	Leinwand, G.	Pocket Books
x. THE COLLEGE DRUG SCENE	Carey, J.	Prentice-Hall
y. NEW SOCIAL DRUG: CULTURAL, MEDICAL & LEGAL PRESPECTIVE ON MARIJUANA	Smith, D.	Prentice-Hall
z. DRUG ADDICTION: PHYSIOLOGICAL, PSYCHOLOGICAL & SOCIOLOGICAL ASPECTS	Ausubel, D.	Random
aa. DRUGS IN CURRENT USE & NEW DRUGS	Modell, W.	Springer
ab. POISONED IVY	Daraff, H.	Tempo (Bantam)
ac. WHAT EVERYONE NEEDS TO KNOW ABOUT DRUGS	-----	US News & World Report

	<u>TITLE</u>	<u>AUTHOR</u>	<u>PUBLISHER</u>
ad.	MESCAL & MERCHANISMS OF HALLUCINATIONS	Kluver, H.	Univ of Chicago Press
ae.	STROKE A SLAIN WARRIOR	Cortina, Frank M.	
af.	DOPE BOOK: ALL ABOUT DRUGS	Lieberman, Mark	
ag.	OVERCOMING DRUGS: A PROGRAM FOR ACTION	Louria, Donald	
ah.	LOVE NEEDS CARE: A HISTORY OF SAN FRANCISCO'S HAIGHT- ASBURY FREE MEDICAL CLINIC	Smith & Luce	
ai.	DRUG EPIDEMIC AND HOW TO COMBAT IT	Westman, Wesley C.	
aj.	IS THE GRASS GREENER? ANSWERS TO QUESTIONS ABOUT DRUGS	Whipple, D. V.	